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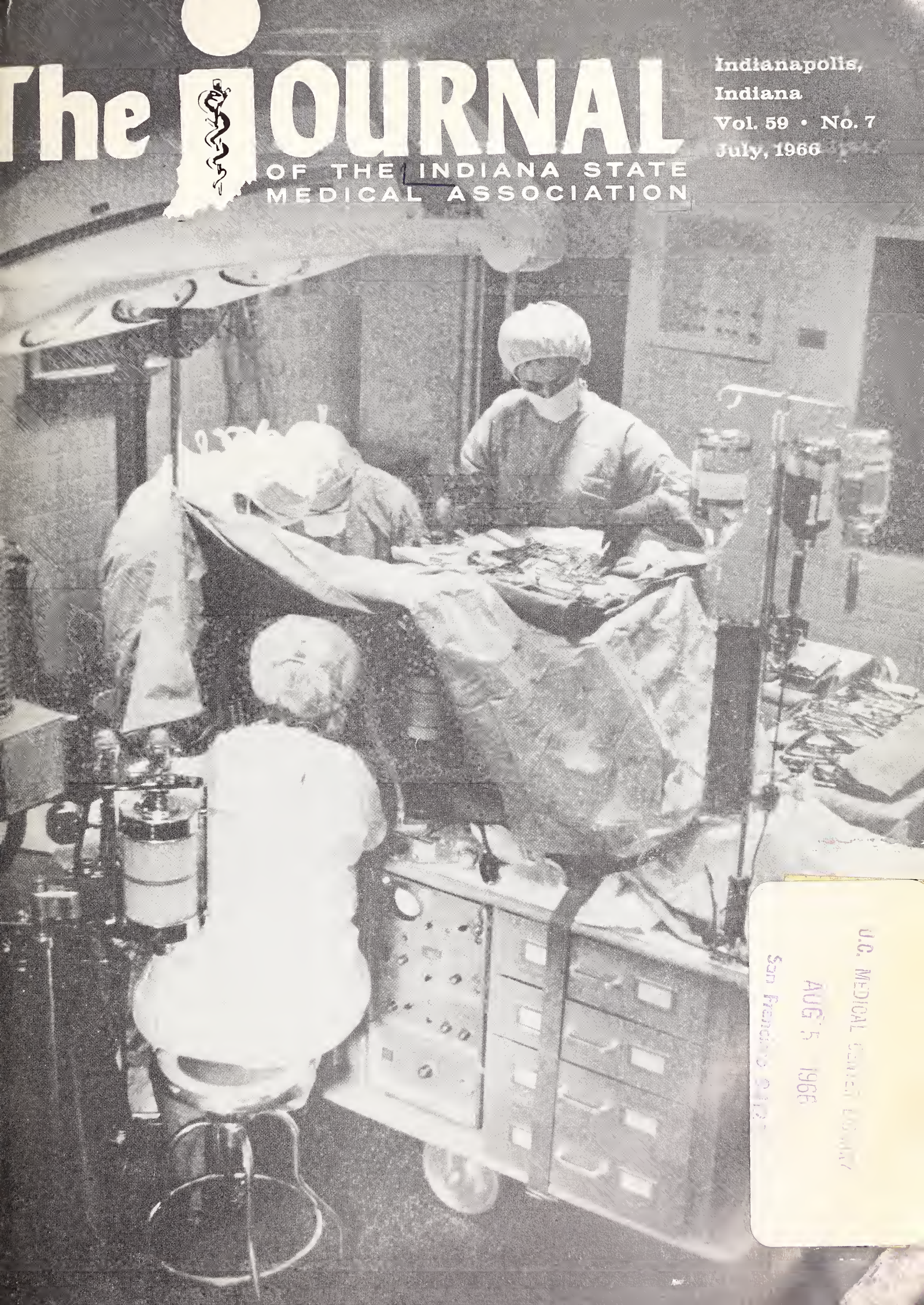
The JOURNAL OF THE INDIANA STATE MEDICAL ASSOCIATION

Indianapolis, Indiana
Vol. 59 • No. 7
July, 1966



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Reese, H. H.: *Wisconsin*

M. J. 15:344, 1939.
higan M. Soc. 38:317,

loran, T. H.: *Ann. Int.*

utnam, T. J.: *Arch. Neu-*
053, 1939.
l Sc. 85:986, 1939.
l, D. L., Jr., and Arnold,
nth. 66:522, 1939.

Osgood, R.: *J.A.M.A.*

nnett, C. L.: *Psychiat.*

Vashington Bull. 3:16.

ldstein, H. H.: *Am. J.*
940.
son, V.: *Ann. Int. Med.*

. M.A.J. 43:157, 1940.

ulane Med. Fac. 1:2,

Times 69:461, 1941.
Shallenberger, D. W.:
383, 1941.
Bull. Veterans Admin.

t 61:178, 1941.

ec. 155:105, 1942.
Psychiat. 98:515,

A. 120:449, 1942.
. Psychiat. 99:231,

es 70:244, 1942.
enner, C.: *J. Nerv. &*
42.
eff, A. J.: *J.A.M.A.*

Queries & Minor Notes: *J.A.M.A.* 124:200, 1944.
Gingrass, R. P.: *Wisconsin M. J.* 43:934, 1944.
Vallotton, C. F.: *Virginia M. Month.* 71:159, 1944.

Butter, A. J. M.: *J. Neurol. Neurosurg. & Psychiat.* 8:49, 1945.
Lennox, W. G.: *M. Clin. North America* 29:1114, 1945.

Bashinsky, B.: *J.M.A. Georgia* 35:228, 1946.

Twitchell-Allen, D.: *Arch. Neurol. & Psychiat.* 57:617, 1947.
Keith, H. M.: *Am. J. Dis. Child.* 74:140, 1947.
Wigton, H. A.: *Nebraska M. J.* 32:272, 1947.
Hoefer, P. F. A.; Hoff, H. H., and Pluvinage, R. I. L.: *Tr. Am. Neurol. A.* 72:185, 1947.

Fabing, H. D., and Hawkins, J. R.: *Ohio M. J.* 44:257, 1948.
Thorne, F. C.: *Am. J. Psychiat.* 104:570, 1948.
DeJong, R. N.: *Am. Practitioner* 3:233, 1948.
Tudor, R. B.: *J. Lancet* 68:391, 1948.

Yannet, H.; Deamer, W. C., and Barba, P. S.: *Pediatrics* 4:677, 1949.
Silverstein, A.: *Am. Practitioner* 3:344, 1949.
Lennox, M. A.: *Am. J. Dis. Child.* 78:868, 1949.

Roseman, E.: *Postgrad. Med.* 8:419, 1950.
Ruskin, D. B.: *Am. J. Psychiat.* 107:415, 1950.
Chaiken, B. H.; Goldberg, B. I., and Segal, J. P.: *New England J. Med.* 242:897, 1950.

Forster, F. M.: *J.A.M.A.* 145:211, 1951.
Bakwin, R. M., and Bakwin, H.: *J. Pediat.* 39:776, 1951.
Ransone, J. T.: *Virginia M. Month.* 78:303, 1951.

Sokolova, E. I.: *Zhur. nevropat. i psikhiat.* 53:385, 1953.

Davidson, D. T., Jr., and Lombroso, C.: *New England J. Med.* 251:853, 897, 1954.
Hopkins, S. J.: *Chemist & Druggist* 161:628, 1954.
Hernandez, R., L.: *J. Am. M. Women's A.* 9:188, 1954.

Drew, A. L.: *Postgrad. Med.* 18:327, 1955.
Williams, E. Y., and Carmichael, C. P.: *J. Nat. M. A.* 47:162, 1955.
Millichap, J. G.; Lombroso, C. P., and Lennox, W. G.: *Pediatrics* 15:705, 1955.

Murphy, J. T., and Schwab, R. S.: *J.A.M.A.* 160:385, 1956.
Livingston, S.: *Postgrad. Med.* 20:584, 1956.
Gruber, C. M., Jr.; Mosier, J. M.; Grant, P., and Glen, R.: *Neurology* 6:640, 1956.
Levy, L., and Shanbrom, E.: *Arch. Int. Med.* 97:599, 1956.
Utterback, R. A.: *Am. Pract. & Digest Treat.* 7:763, 1956.
Zimmerman, F. T.: *New York J. Med.* 56:2537, 1956.

Berry, R. G., in Spiegel, E. A. (ed.): Progress in Neurology and Psychiatry, New York, Grune & Stratton, 1957, vol. 12, pp. 199-211.
Daly, D. D.: *Proc. Staff Meet. Mayo Clin.* 32:257, 1957.
French, E. G.: *Am. J. Psychiat.* 113:629, 1957.
Maltby, G. L.: *J. Maine M. A.* 48:257, 1957.

Rupp, C., Jr.: *J.A.M.A.* 166:1967, 1958.
Peterman, M. G.: *Minnesota Med.* 41:196, 1958.
Livingston, S.: *J. Lancet* 78:182, 1958.
Carter, C. H.: *Arch. Neurol. & Psychiat.* 79:136, 1958.
Keith, H. M.: *J. Lancet* 78:461, 1958.
Farmer, T. W.: *South. M. J.* 51:173, 1958.

Yahr, M. D., and Merritt, H. H.
Neurol. 1:76, 1959.
Thomas, M. H.: *J.A.M.A.* 169:
Peterman, M. G., and Thomas
Times 87:1044, 1959.
Bray, P. F.: *Pediatrics* 23:151,
Mulder, D. W.; Daly, D. D.; Rus
and Yoss, R. E.: *Postgrad. Med*
1959.
Forster, F. M.: *Wisconsin M. J.*
1959.
Robertson, E. G.: *Postgrad. Me*
1959.

Schwade, E. D.: *Geriatrics* 15:
Schade, G. H., and Gofman, H.
25:151, 1960.
Forster, F. M.: *Postgrad. Med.*
1960.
Livingston, S.: *J.A.M.A.* 174:13
Friedlander, W. J.: *Am. J. Psych*
1960.

Kane, C. A.: *Boston Med. Quart*
1961.
Holowach, J.; Renda, Y. A., and
J. Pediat. 59:339, 1961.
Baker, A. B.: *J. Lancet* 81:235,
Roseman, E.: *Neurology* 11:91

Gruber, C. M., Jr.; Brock, J. T.,
M.: *Clin. Pharmacol. & Therap.*
Walker, A. E.: *World Neurol.* 3:1

Pauli, L. L.: *Maryland M. J.* 12:4
Livingston, S.: *Clin. Pediat.* 2:23
Forster, F. M.: *M. Clin. North Ar*
47:1579, 1963.
Scholl, M. L.: *New England J. M*
269:1304, 1963.

Kutt, H.; Winters, W.; Kokenge,
McDowell, F.: *Arch. Neurol.* 11:
Currier, R. D.: *GP* 30:125, 1964
Chao, D.; Sexton, J. A., and Davi
J. Pediat. 64:499, 1964.

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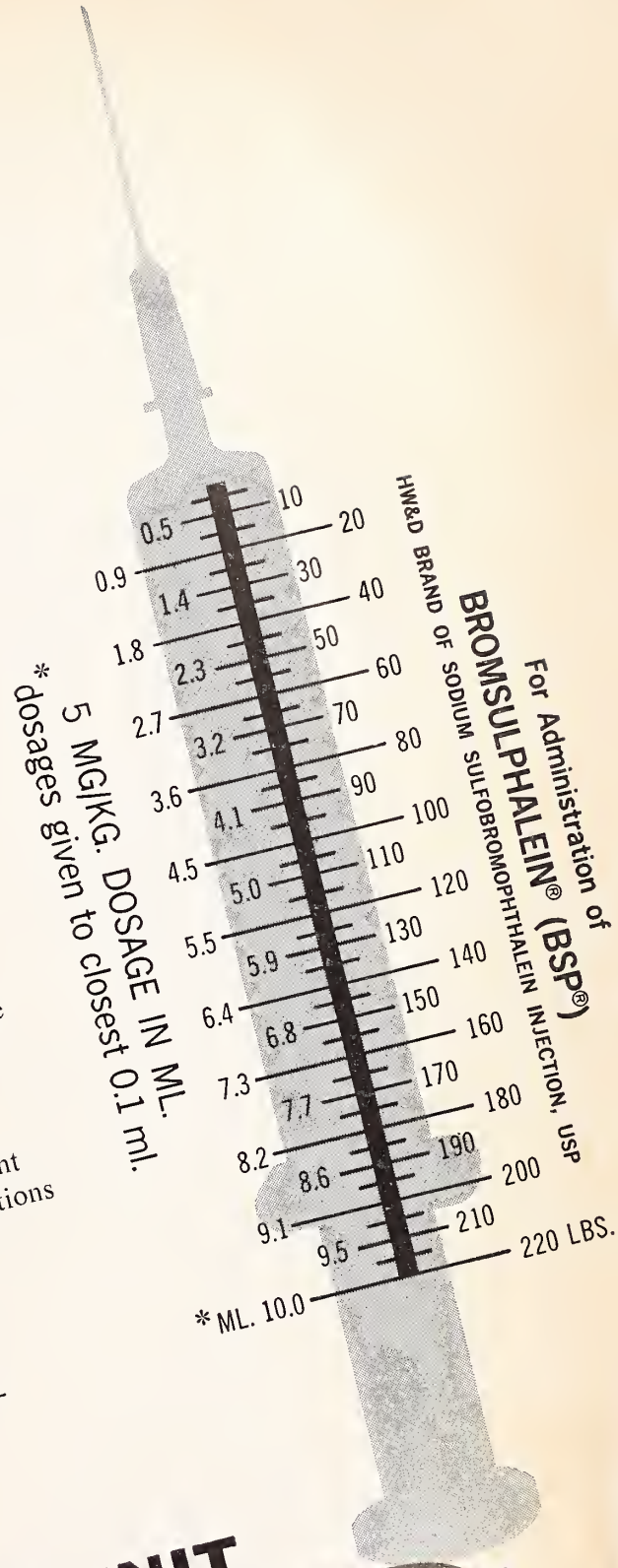

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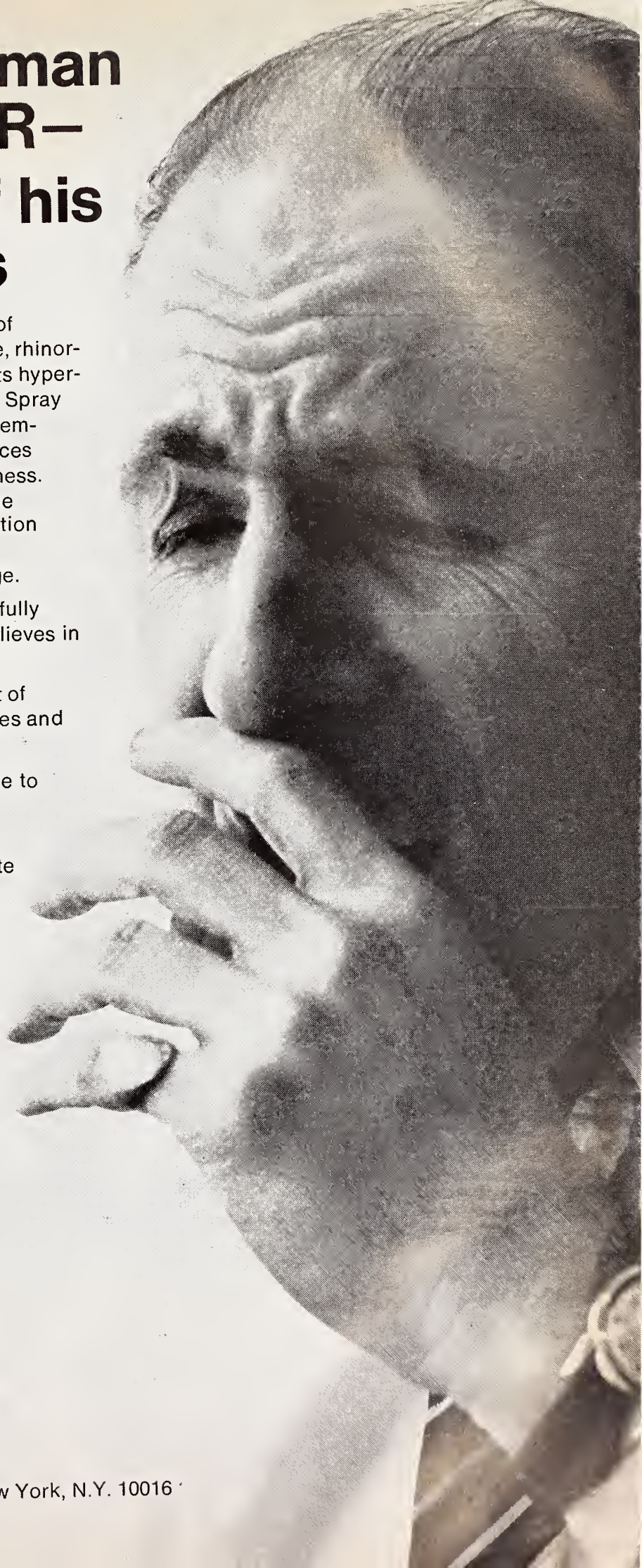

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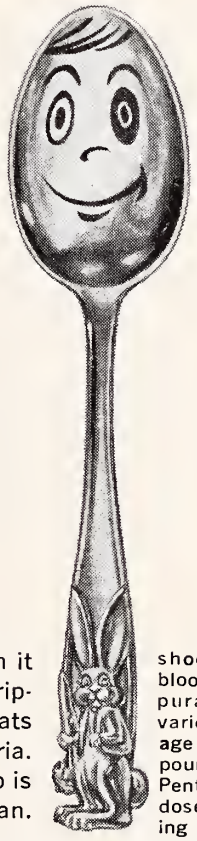

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2.	C. Philip Fox, Washington	J. S. Brown, Carlisle	
3.	Daniel H. Cannon, New Albany	Elmer L. Wallace, New Albany	May 17, 1967
4.	Harold W. Richmond, Columbus	David L. Adler, Columbus	
5.	John Ellett, Jr., Coatesville	Richard Veach, Bainbridge	Greencastle, May 17, 1967
6.	J. J. Farrell, Jr., Greenfield	Stephen D. Smith, Knightstown	Columbus
7.	Jay Reese, Martinsville	James H. Gossman, Indianapolis	
8.	Donald E. Spahr, Portland	Joseph F. Vormohr, Portland	Portland, June 7, 1967
9.	Harry T. Stout, Frankfort	Earl K. Williams, Frankfort	May 18, 1967
10.	Leslie Bombar, Munster	Louis Kudele, Whiting	
11.	Reeve B. Peare, Huntington	Carl Ray, Warren	Kokomo, Sept. 21, 1966
12.	Warren L. Niccum, Columbia City	Kenneth F. Isenogle, Fort Wayne	Fort Wayne, May 18, 1967
13.	James W. Hurley, Elkhart	Cecil R. Burket, Bremen	Elkhart, Sept. 14, 1966

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It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards; they all are underpaid, too. Therefore, all interns are alike.

That's utter nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

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You might also say that all interns aren't alike, either.

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mood elevation

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Program

DESOXYN® Gradumet® (methamphetamine hydrochloride)

Smooth appetite control plus mood elevation.

The obese patient on a diet often has to battle depression as well as overweight. Desoxyn Gradumet helps the dieter in both battles by elevating the mood while it curbs the appetite. Thanks to the Gradumet, medication is smoothly released all-day from a single oral dose.

If she can't take plain amphetamine, put her on DESBUTAL® Gradumet

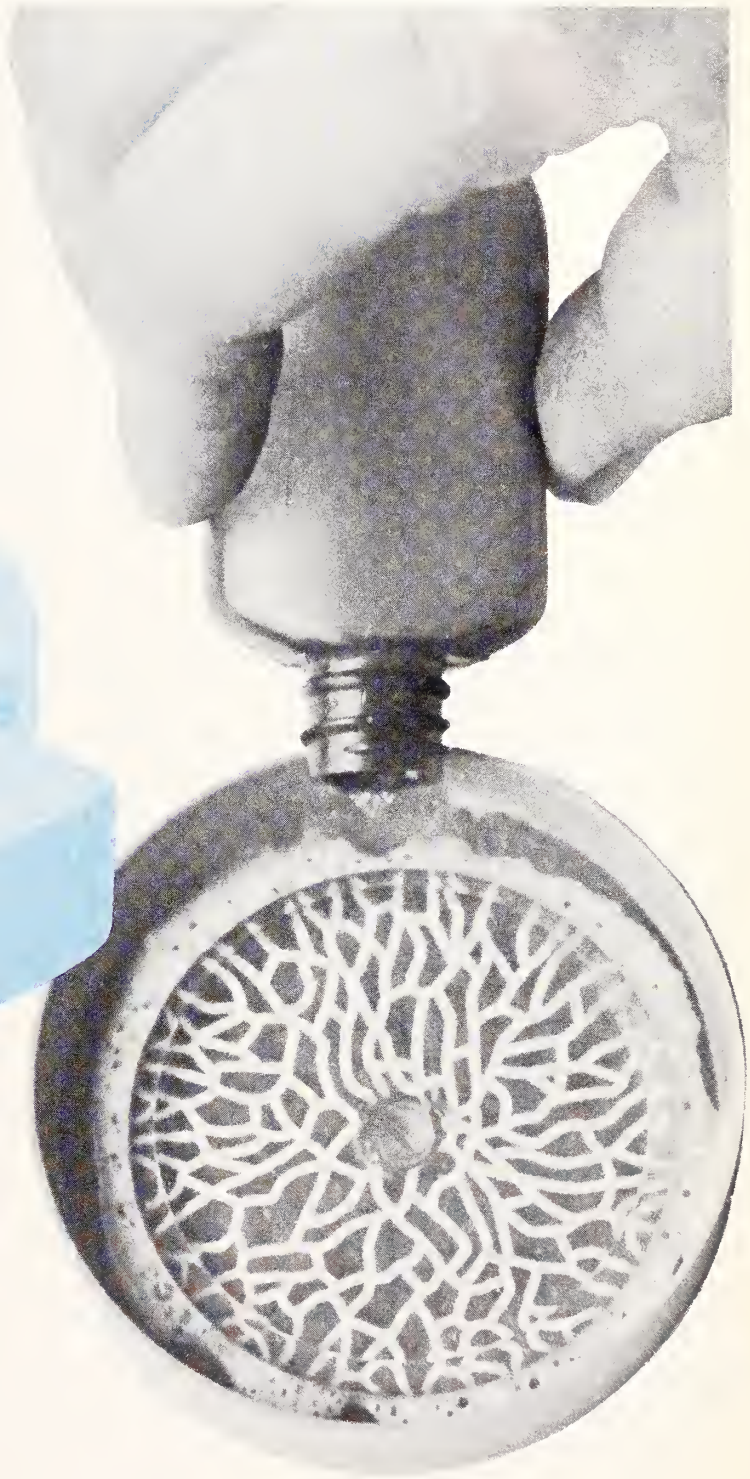
Calms anxieties; controls compulsive eating.

Desbutal Gradumet provides 2 drugs in 2 tablet sections, combined back to back to form a single tablet. One section contains Desoxyn to curb the appetite and lift the mood; the other contains Nembutal® (pentobarbital) to calm the patient and counteract any excessive stimulation.

Both drugs are released in an effective dosage ratio throughout the day.

controlled release

Not all long-release vehicles are the same. Here is why the Gradumet is different and what it means for your overweight patients.



The release action is purely physical and relies on only one factor common to every patient: gastrointestinal fluid. There is no dependence on enteric coatings, enzymes, motility, or an "ideal" ion concentration in the gastrointestinal tract.

Your patients get a measured amount of medication, moment by moment, throughout the day.

They are not subjected to ups and downs of drug release . . . or to erratic release from patient to patient . . . or to erratic release in the same patient from day to day.

That's why the Gradumet provides controlled-release as well as long release.

Perhaps you saw the Gradumet model demonstration which shows that the release is entirely physical. When fluid is added, the drug in the outer ends of the channels dissolves. As fluid penetrates deeper into the channels, there is a continuous release of medication. The rate of release is rigidly controlled by the size and number of channels.

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DESOXYN Gradumet
Methamphetamine Hydrochloride in Long-Release Dose Form

5 mg. 10 mg. 15 mg.

DESBUTAL 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Pentobarbital Sodium

Front Side

DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Pentobarbital Sodium

Front Side

samples available

Each sample contains 6 tablets and a filled Sucaryl® Sweetener dispenser. For a supply, write Abbott Laboratories or ask your Abbott man.

Desbutal 15 Gradumet

Product of choice for patients who overreact to plain amphetamine

INDICATIONS: As an anorectic in treatment of obesity; also to counteract anxiety and mild depression.

CONTRAINDICATIONS: Desbutal is contraindicated in patients taking a monoamine oxidase inhibitor. Nervousness or excessive sedation have occasionally been observed, often these effects will disappear after a few days. Use with caution in patients with hypertension, cardiovascular disease, hyperthyroidism or who are sensitive to sympathomimetic drugs. Careful supervision is advisable with maladjusted individuals.

DOSAGE: A single Gradumet tablet in the morning provides all-day appetite control.

SUPPLIED: Desbutal 10 contains 10 mg. of methamphetamine hydrochloride and 60 mg. of pentobarbital sodium. Desbutal 15 contains 15 mg. of methamphetamine hydrochloride and 90 mg. of pentobarbital sodium. In bottles of 100 and 500

Sucaryl Brand Sweeteners

A proven aid to weight control—

For use in beverages and foods —stable to heat

A constant reminder to your patient to "watch her calories"

A carefully balanced formula to prevent aftertaste

—in tablets and liquid—

Sucaryl—Abbott brand of low and non-caloric sweeteners

Press out tablets from this side. LOT NO. 784-1331

For:

Directions:

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economy

Patients, in many cases, save enough to get five weeks of medication for the price of four, compared to other leading long-release anorectics.

CONTRAINDICATION: Desoxyn and Desbutal are contraindicated in patients taking a monoamine oxidase inhibitor.

PRECAUTIONS: Use with caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs or ephedrine and its derivatives. Careful supervision is advisable with maladjusted individuals.

ABBOTT

Gradumet—long-release dose form, Abbott: U.S. Pat. No. 2,987,445.
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The human spine is not engineered for prolonged sitting at desks, pianos, typewriters and drafting boards. The stresses set up by the heavy, forward-tilted head and trunk, balanced precariously on an insufficient base, result in strain of the dorsal musculature, particularly at the low lumbar level.

The unusual muscle-relaxant and analgesic properties of 'Soma' make it especially useful in the treatment of low back sprains and strains. 'Soma' is widely prescribed ☐ **to relieve pain** ☐ **to relax muscles** ☐ **to restore mobility.**

Indications: 'Soma' is useful for management of muscle spasm, pain, and stiffness in a variety of inflammatory, traumatic, and degenerative musculoskeletal conditions. It also may act to normalize motor activity in certain neurologic disturbances.

Contraindications: Allergic or idiosyncratic reactions to carisoprodol.

Precautions: 'Soma', like other central nervous system depressants, should be used with caution in patients with known propensity for taking excessive quantities of drugs and in patients with known sensitivity to compounds of similar chemical structure, e.g., meprobamate.

Side Effects: The only side effect reported with any frequency is sleepiness, usually on higher than recommended doses. An occasional patient may not tolerate carisoprodol because of an individual reaction, such as a sensation of weakness. Other rarely observed reactions have included dizziness, ataxia, tremor, agitation, irritability, headache, increase in eosinophil count, flushing of face, and gastrointestinal symptoms.

One instance each of pancytopenia and leukopenia, occurring when carisoprodol was administered with other drugs, has been reported, as has an instance of fixed drug eruption with carisoprodol and subsequent cross reaction to meprobamate. Rare allergic reactions, usually mild, have included one case each of anaphylactoid reaction with mild shock and angioneurotic edema with respiratory difficulty, both reversed with appropriate therapy. In cases of allergic or hypersensitivity reactions, carisoprodol should be discontinued and appropriate therapy initiated. Suicidal attempts may produce coma and/or mild shock and respiratory depression.

Dosage: Usual adult dose is one 350 mg. tablet three times daily and at bedtime.

Supplied: Two Strengths: 350 mg. white tablets and 250 mg. orange, two-piece capsules.

Before prescribing, consult package circular.

for the relief of low back sprains and strains

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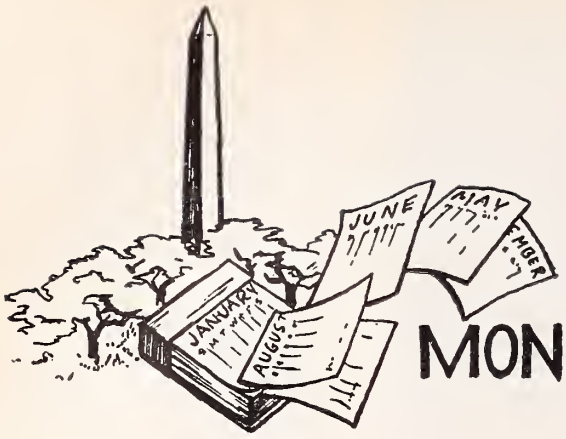


This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

MONTH IN WASHINGTON

WASHINGTON, D.C.—Administration officials say that the doctor-patient relationship should not be impaired under Medicare.

DR. PHILIP R. LEE, assistant secretary of health, education and welfare for health and scientific affairs, said in an interview that federal officials, in drafting Medicare regulations, had been doing their utmost to insure that the traditional doctor-patient relationship is preserved.

"THE GUIDELINES for the Medicare program were developed with the close cooperation of so many physicians and other people in the health care field that this will provide the best assurance for the physicians, for the government, for Congress and for the public that the implementation of Medicare will not alter the fundamental and vital personal relationship between the doctor and the patient," Lee said.

"THIS WAS clearly the intent of Congress."

LEE TERMED the cooperation of physicians and hospital officials in developing Medicare guidelines as "extraordinary." He said he personally expects the doctor-patient relationship to improve under Medicare because removal to a large extent of the financing problem will give a physician more leeway in ordering laboratory tests and sending a patient to a hospital.

"OUR MOST important concern in implementing the Medicare program is education," Lee said. "The education extends to the doctor, the patient and administrators of the program."

LEE'S OFFICE published a brochure for patients and another for doctors explaining what the medical insurance program does and does not do.

THE SOCIAL Security Administration said that nine out of 10 of those 65 and over had enrolled in Plan B of Medicare by the second signup deadline of midnight, May 31. The original deadline was extended for two months in an effort to get a reply from as many as possible of the 19.1 million aged persons eligible. More than 400,000 signed up during the two months, bringing the total to about 17.2 million. About one million said they didn't want Plan B coverage. Those who did not sign up this time will not have another opportunity until Oct. 1, 1967, and they then will have to pay at least 10% higher premiums.

PRESIDENT JOHNSON invited about 200 physicians and hospital administrators to a White House meeting on June 15 "to examine problems that may arise and to discuss cooperative arrangements so that the (Medicare) program will get off to a good start."

Continued on page 786.

SPECIALIZED FACILITIES FOR CUSTODIAL GERIATRIC PATIENTS

We have a limited number of facilities available

With the increased demand for geriatric facilities, The Emerson A. North Hospital is uniquely qualified to offer specialized advantages not found in nursing homes:

Specialized medical staff, including:

- Full time medical director
- 24 hour medical coverage by both physicians and registered nurses
- Recreational therapist
- Occupational therapist
- Psychiatric nursing

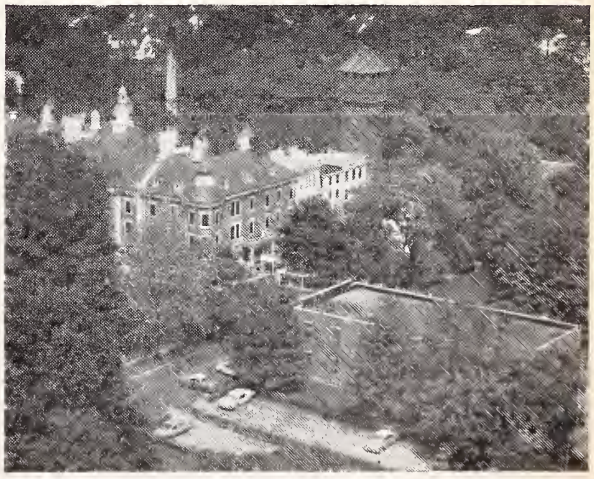
Classification of patients for both acute and geriatric cases:

- 4 classifications for male patients
- 5 classifications for female patients

Beautiful setting in 40 acres of private estate grounds
Cheerful home-like surroundings

In addition to geriatric, we still have complete facilities for psychiatric cases of all ages—as a fully accredited private psychiatric hospital.

Call or write for complete information and rate card.



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When thiazide or reserpine alone won't keep

Establish and maintain early, more decisive control of blood pressure

DIUTENSEN®-R

Cryptenamine 1.0 mg.* Methyclothiazide 2.5 mg. Reserpine 0.1 mg.

When blood pressure won't stay down despite initial therapy—when complaints of headache, fatigue or dizziness are often voiced—it may be time for a change to DIUTENSEN-R.

DIUTENSEN-R is thiazide and reserpine *plus cryptenamine*—a rational, comprehensive therapy to help establish and maintain early, more decisive control of blood pressure.

The cryptenamine in DIUTENSEN-R helps improve normal vasodilating reflexes while the thiazide and reserpine components maintain vasorelaxant, sedative, and saluretic benefits. Cryptenamine lowers pressoreceptor reflex thresholds (which may be abnormally high in hypertension)—"resets" pressoreceptors to function at more nearly normotensive levels.

Early, more decisive control with DIUTENSEN-R helps secure continuing benefits—may reduce or even obviate the need for poorly tolerated drugs later in therapy.

"...quite apart from the problem of vascular damage, there arises a possibility of virtual 'cure' or remission of hypertension when treatment is early, i.e., before too many other secondary pressor systems have entered into the disequilibrium of pressor control, and when it is adequately suppressive."

Corcoran, A. C.: The choice of drugs in the treatment of hypertension. In: Drugs of Choice 1966-67, W. Modell, Ed., St. Louis, C. V. Mosby Company, 1966, p. 417.

Indications: DIUTENSEN-R may be employed in all grades of essential hypertension. **Dosages:** Usual dose is 1 tablet twice daily, at morning and evening meals. However, adjustment of dosage to suit individual circumstances may be required. Please refer to package insert for full particulars. **Side effects and precautions:** The side effects observed with patients on DIUTENSEN-R have been of a mild and nonlimiting nature. These include occasional urinary frequency, nocturia, nasal congestion, muscle cramps, skin rash, joint pains due to gout symptoms and nausea and dizziness which have been reported for the individual components. Most of these symptoms disappear while the drug is continued at the same or lower dosage level. The concomitant use of digitalis and DIUTENSEN-R may increase the possibility of digitalis-like intoxication. If there is evidence of myocardial irritability (extrasystoles, bigeminy or AV block), dosage of DIUTENSEN-R should be reduced or discontinued. Nocturia in patients with marginal cardiac status and salt and fluid retention can be effectively controlled by limiting the time of administration to early afternoon. DIUTENSEN-R should not be used in patients with a known intolerance to reserpine. Package inserts furnish a complete summary of recommended cautions related to each of the ingredients of DIUTENSEN-R.

*As tannate salts equivalent to 130 Carotid Sinus Reflex Units.

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Continued

IN ADDITION to Johnson, speakers at the meeting included HEW Secretary John W. Gardner; HEW Undersecretary Wilbur J. Cohen; Lee; Surgeon General William H. Stewart; Social Security Commissioner Robert M. Ball, and Arthur E. Hess, director of Medicare.

SOCIAL SECURITY headquarters at Baltimore set up an around-the-clock Medicare information service to help its district offices in responding to queries from beneficiaries, physicians, hospital administrators and others.

PHYSICIAN DRAFT CALL CUT

THE DEFENSE Department has slashed by almost one-third—from 2,496 to 1,713—its special draft call for physicians to be delivered to the armed forces this summer.

UNDER THE revised doctor draft call, the Army will take 958, the Navy 405 and the Air Force 350.

THE PENTAGON said casualties in Southeast Asia had been fewer than expected and the number of volunteer physicians had exceeded estimates. In reducing the call by 783, the Defense Department pointed out it had originally issued its request to Selective Service last February. At that time, it used the best estimates available on the number of additional physicians who would be needed for the buildup of the armed forces in connection with the Viet Nam war.

VICTIMS OF SWINDLES TO BE STUDIED

THE FEDERAL government will conduct a nationwide survey to determine factors that lead people, particularly older persons, to fall for fakes and swindles in the health field.

SEVEN AGENCIES of the government are joining in the study which was recommended by the Senate Special Committee on Aging Subcommittee on Frauds and Misrepresentations Affecting the Elderly. The study will include various age groups beginning with teen-agers, but it will focus on the elderly.

AT HEARINGS of the subcommittee, it was estimated that a billion dollars is wasted each year on misrepresented, unnecessary or worthless health products and services with a large share of such spending by older persons, especially those suffering from chronic and incurable diseases.

THERE IS general agreement among the government agencies involved that this waste of money may be greatly reduced if more knowledge is available about why people become victims of medical quackery.

THE FOOD and Drug Administration is coordinating the study. Joining with FDA in the survey project are the Administration on Aging; National Institute of Child Health and Human Development; National Institute of Mental Health; and Vocational Rehabilitation Administration—all within the Department of Health, Education, and Welfare; the Agricultural Research Service of the U. S. Department of Agriculture, and the Veterans Administration. A number of voluntary health agencies, the American Medical Association and the National Better Business Bureau helped in planning the study.

THE STUDY will seek to determine the influence of such factors as family and educational background, folk medicine customs, and health experiences on consumer attitudes toward health products, services and information. It will examine the extent to which such factors make some individuals prone to accept false and misleading promotions for health products and services, or resistant to sound medical and health information.

Continued

after surgery

B and C vitamins are therapy: Therapeutic amounts of B and C in stress formula vitamins often are vital during periods of physiologic stress. STRESSCAPS capsules, designed to meet increased metabolic demands, aid in achieving a more comfortable convalescence, a more rapid recovery. After surgery, as in many stress conditions, STRESSCAPS vitamins are therapy.

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Vitamin B_1 (Thiamine Mononitrate)	10 mg
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Vitamin B_6 (Pyridoxine HCl)	2 mg
Vitamin B_{12} Crystalline	4 mcgm
Vitamin C (Ascorbic Acid)	300 mg
Niacinamide	100 mg
Calcium Pantothenate	20 mg

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

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Armed with such knowledge, the agencies hope to be able to devise more effective educational and other programs to protect the public against health frauds and quackery.

PHS TO BE REORGANIZED?

HEW SECRETARY John W. Gardner plans to reorganize the Public Health Service to give the Surgeon General more control over eight new divisions which would replace the present eight.

ONE OF THE new eight major divisions would be a National Institute of Mental Health which is now lumped under the National Institutes of Health. The new national institute will include the Fort Worth and Lexington Narcotics Hospitals and will "administer a unified program of research, manpower training, demonstrations and mental health services." Gardner said the institute will "serve as the principal focus for research and control programs in alcoholism and drug addiction."

THE OTHER SEVEN new divisions would be the National Institutes of Health, the Bureau of Health Services, the Bureau of Health Manpower, the Bureau of Disease and Injury Prevention and Control, the National Library of Medicine, the National Center for Health Statistics and Surgeon General's office.

GARDNER ALSO told a House Commerce Subcommittee that studies are underway to reorganize HEW into a Pentagon-type organization with a super-type secretary over three separate secretaries of Health, Education and Welfare. But he said "now is not the time to act on those proposals."

GARDNER'S PUBLIC Health Service reorganization plan transfers to the secretary all functions of the Public Health Service, the Surgeon General and all other agencies in the service. Gardner called the present structure of the Public Health Service "obsolete." He pointed out it was unchanged since 1943 when the service had a budget of $52 million compared to the present budget of $2.4 billion.

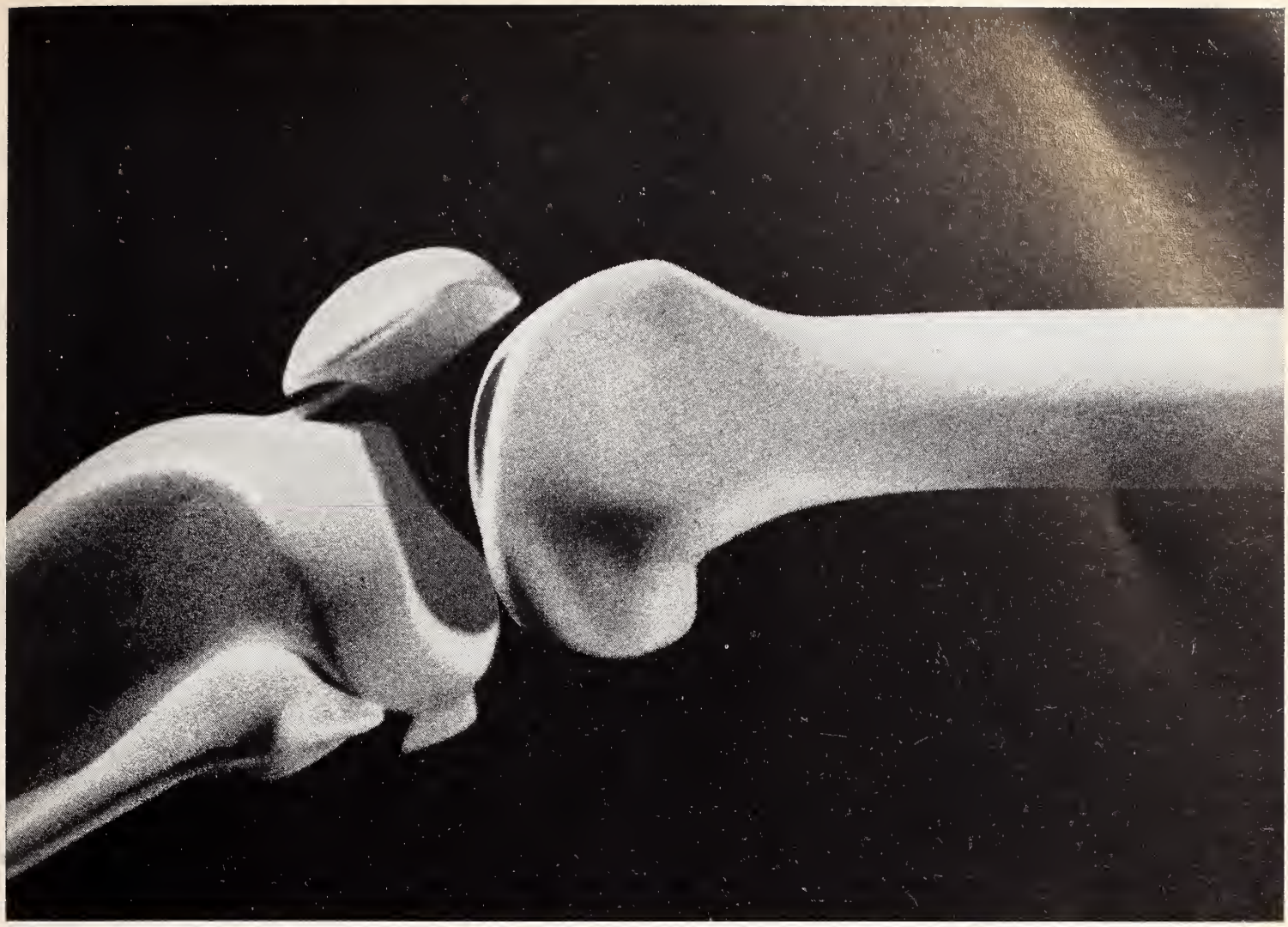
WATER POLLUTION CONTROL SHIFTED

WATER POLLUTION control activities of the federal government now are under the Interior Department.

THE SHIFT from the Department of Health, Education and Welfare became official when Congress didn't veto President Johnson's reorganization request for the move. Johnson predicted the federal government "now is better organized to carry out concerted action against the pollution that blights America's waters."

INTERIOR SECRETARY Stewart Udall promptly issued guidelines to the states for setting water quality standards designed "to make rivers as clean as possible," instead of "as clean as permissible."

UDALL OUTLINED the department's goal as a federal-state approach to assure a national supply of clean water necessary for health and economic growth. ◄



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Usually works within 3 to 4 days in osteoarthritis

The trial period need not exceed 1 week. In contrast, the recommended trial period for indomethacin is *at least 1 month.*

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A large number of investigators have reported major improvement in about 75% of cases. Some patients have gone into remission. Relief of stiffness and pain may be followed quickly by improved function and resolution of other signs of inflammation. And Butazolidin alka is well tolerated, especially since it contains antacids and an antispasmodic to minimize gastric upset.

Contraindications
Edema, danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile, or when other potent drugs are given concurrently. Large doses are contraindicated in patients with glaucoma.

Precautions
Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Make regular blood counts. Use greater care in the elderly.

Warning
If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy.

Adverse Reactions
The most common are nausea, edema and drug rash. Hemodilution may cause moderate fall in red cell count. The drug may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

Dosage
The initial daily dosage in adults is 300-600 mg. daily in divided doses. In most instances, 400 mg. daily is sufficient. When improvement occurs, dosage should be decreased to the minimum effective level: this should not exceed 400 mg. daily, and is often achieved with only 100-200 mg. daily.

Also available: Butazolidin®, brand of phenylbutazone Tablets of 100 mg.

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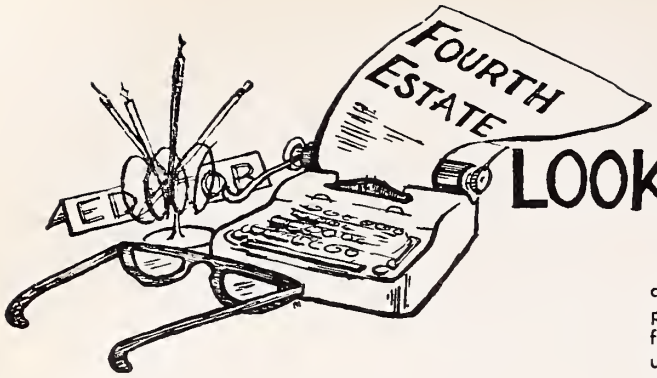

LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

A Salute To Lilly

The research scientists, the executives, marketing experts and skilled employees of Eli Lilly and Company would be the last to call themselves miracle workers, and yet the phrase applies to the things they do.

This firm, truly an aristocrat among the businesses of Indianapolis and the nation, marks its 90th birthday today, ending a year of solid accomplishments and starting one that is certain to bring more. Its sales and earnings have been the highest in the company history, exceeding the $300 million mark for the first time. It has built new plants and facilities and branches in Lafayette, Puerto Rico, Taiwan and Japan and is constructing new research facilities near London, England.

These will increase the production of Lilly plants all over the world which now employ more than 15,000 persons.

The firm is marketing a new antibiotic, an oral treatment for diabetes, new herbicides and an oral contraceptive that could become an important factor in helping stem the population explosion in underdeveloped countries.

Lilly products number in the thousands. The stories behind the development and discovery of many of them are among the most exciting, dramatic and significant in the history of medicine. There is no way of calculating the number of lives they have saved and the number of individuals they have spared from the twilight-life of ill health once thought incurable, and from suffering pain.

To these accomplishments must be added the strides that Lilly research and manufacture have taken in producing healthier livestock and improved output of agricultural crops, which have increased the health and strength of the American people and millions of people overseas.

Eli Lilly and Company is certain to blaze new trails and reach new horizons this year and in the years to come.

Today we salute this great company and the fine men and women who have made and are making it what it is. — *The Indianapolis Star*, May 10, 1966.

Is There a Doctor Available?

Recently compiled statistics reveal some rather startling figures concerning the medical profession, and in particular with relation to the state of Indiana. Our state, the eleventh in size in the nation, has had a steady decline in the number of physicians available to serve the people during the last 40 years.

The national average now is 143 doctors per 100,000 people. This is one doctor for every 700 people. Indiana now ranks 34th in the physician-to-population ratio, with 84 doctors for 100,000 people. The way we figure it, that's about one medic for 1,190 folks.

Authorities say there should be at least one doctor for 1,000 people. Brown county, with more than 7,000 people, has only one doctor. Martin county has more than 5,000 potential patients per doctor.

Miami county, with a population of about 38,000, should have 38 doctors. Actually the latest count showed only 14.

Little wonder that our physicians are over-worked and hard to find. It is understandable why sick people, especially those of inferior intelligence, drift to the quacks and "healers."

It is our opinion that the doctors themselves, with the connivance of the medical colleges, have brought this situation about. They have set the standards of the profession so high, and made a legal degree so difficult to attain, that thousands of young men who would make splendid physicians go into other fields of endeavor which permit them to live a normal life.

We think our legislators should consider amending the laws governing this noble profession to permit students slightly below the genius class to get into it. We need more general practitioners with a blend of technical skill and common sense. — *The Wabash Times*, May 5, 1966.

Keep The Patient In Mind

In the squabble over the method of handling fees of pathologists and radiologists in hospital care billings, we hope the interests of the patients will not get submerged.

We do not intend to imply that those on either side would consciously let that happen. The spokesmen on both sides declare — and we think they are sincere — that the best interest of the patient would be served by their particular solution. They can't both be right.

The first and foremost interest of the patient, of course, is the quality and appropriate speed of the work. We have no doubt that this interest will

continue to be served as well as humanly possible, regardless of the outcome of this controversy. This is not what worries us.

Another interest of the patient, admittedly secondary but nonetheless of very great importance, is the price of hospital and medical care. This is the interest which could suffer in this quarrel.

We have no side to take in the controversy. We do find one point in the existing situation, however, which seems definitely open to question. It has been said that operation of radiology and pathology departments has been very profitable for most hospitals, which use the profits to help defray losses of other operations. It has been said also that radiologists and pathologists profit handsomely, which is something for the members of the medical profession to judge.

Almost every patient who enters a hospital has some need for the services of one or the other of these departments. But some patients have a great deal more need for them than others. These are likely to be the patients whose hospital and medical bills will be the highest, in any event. It does not seem fair to load the hospital bills of these patients with profits on their needed services, to help pay for services provided to other patients.

It seems to us to be in the best financial interest of the patient — each patient — to price each hospital service as accurately as possible in proportion to its necessary cost. Overhead costs should be distributed as evenly as possible into the charges for various services. Each patient's bill should reflect as closely as possible his fair share of the cost of his care, but no more.

We earnestly urge those who must settle this matter to use as one of their guideposts the aim of achieving the lowest total price to the patient consonant with a given net return to both hospitals and doctors. — *The Indianapolis Star*, May 22, 1966.

Mastering Measles

From all indications, so far, a nation-wide measles epidemic forecast for 1966 isn't materializing, thanks to an effective vaccine, health authorities report.

The vaccine, developed by the Pitman-Moore Division of Dow Chemical Company in Indianapolis, has been so effective that many cities, and entire states, have reported no cases of measles for the first time in history.

The live-measles vaccine called the Schwarz strain may lead to the eradication of the disease. Although termed a "needless disease" by health authorities, measles has been responsible for nearly 400 deaths a year in the U.S. among children and untold cases of mental retardation, ear damage and other lasting effects.

This is proof positive that drug research by the pharmaceutical companies is paying off — in terms of making man's life healthier through eradication of diseases that once were the scourge of the masses.

Indianapolis should be proud that the vaccine was developed here. — *The Indianapolis Star*, May 12, 1966.

More Medical Bills To Pay

The increase in Social Security payroll taxes to meet the initial costs of Medicare was a jolting reminder, which may now be wearing off a little, that these things must be paid for. There's more to come from this legislation.

One of the things yet to come is a program known as Title 19 of the Medicare bill. It offers funds, to be matched by state funds, for medical care for which some 35 million persons of all ages are potentially eligible. This is distinct from the Medicare program, and is not covered by the Social Security tax.

Medical care under Title 19 would be offered to all persons on public assistance rolls, to a vaguely defined group of persons who would be eligible for public assistance except for incomes above state ceilings, and to persons who cannot qualify for public assistance but who "cannot afford" to pay for their minor children's medical needs.

That's quite a package. It requires state legislation to set up programs on a state basis. Eight states and one territory so far have done this, and about 20 others are expected to do so by the end of 1966. No doubt the matter will be presented to the Indiana General Assembly next year.

What this will cost no one knows. Whatever it is will be another new tax burden at both the federal and state levels.

In addition, there has also begun a new push for general Federal funds to augment Social Security payments. A Senate subcommittee on services to the elderly has made such a recommendation. The subcommittee says present benefit payments are too low, and recognizes that higher payments could not be financed out of the Social Security tax. Hence the proposal to tap general tax revenues to raise the monthly Social Security checks.

This proposal has been made before, without stirring up much enthusiasm. In the near future, however, the situation may be more ripe for it. Another thing no one knows is what the costs of Medicare to come out of Social Security funds will be. It is entirely possible that they will be higher than the revenues from the Social Security tax increase provided in the Medicare bill. If that happens, there undoubtedly will be pressure to cover the deficiency out of general tax revenues. This in turn would encourage the idea of tapping the same source for more money to pay regular Social Security benefits.

It's all bad news for the taxpayer. — *The Indianapolis Star*, May 26, 1966. ◄

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Erythromycin Estolate

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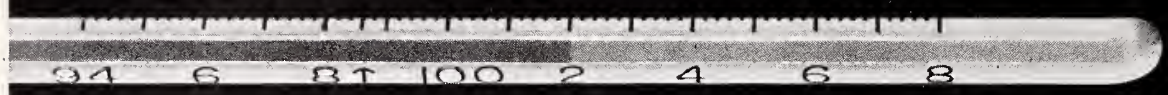

two to four times the therapeutic activity of other erythromycins

CONTRAINDICATIONS: Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with preexisting liver disease or dysfunction.

SIDE-EFFECTS: Even though Ilosone is the most active oral form of erythromycin, the incidence of side-effects is low. Infrequent cases of drug idiosyncrasy, manifested by a form of intrahepatic cholestatic jaundice, have been reported. There have been no known fatal or definite residual effects. Gastro-intestinal disturbances not associated with hepatic effects are observed in a small proportion of patients as a result of a local stimulating action of Ilosone on the alimentary tract. Although allergic manifestations are uncommon with the use of erythromycin, there have been occasional reports of urticaria, skin eruptions, and, on rare occasions, anaphylaxis.

DOSAGE: *Children under 25 pounds*—5 mg. per pound of body weight every six hours. *Children 25 to 50 pounds*—125 mg. every six hours. *Adults and children over 50 pounds*—250 mg. every six hours. For severe infections, these dosages may be doubled.

Available in Pulvules®, suspension, drops, and chewable tablets. Ilosone Chewable tablets should be chewed or crushed and swallowed with water.

Additional information available to physicians upon request.
Eli Lilly and Company, Indianapolis, Indiana 46206.

Lilly

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The Journal
of the INDIANA STATE MEDICAL ASSOCIATION
Supervised by The COUNCIL
Volume 59 — July 1966 — Number 7

Pregnancy complicated by severe polyhydramnios successfully managed with survival of the mother.

Extreme Polyhydramnios: A Case Report

F. B. KANTZER, M.D.
Garrett

THE patient, a 34-year-old white female, was seen in March, 1965, in her ninth pregnancy. She had had seven living children; the oldest was 14 and the youngest was six years old.

The eighth pregnancy had been terminated by a spontaneous abortion in 1962, following which a curettage was performed and degenerated placenta removed.

All other pregnancies were normal; the deliveries were also normal and without incident. All blood serologic reactions were negative. Her blood pressure had varied during pregnancy from 110/74 to 124/80. Urinalyses were consistently negative for sugar and albumin.

She was first seen by the author in November, 1961, when she reported that there had been no menses since the previous July. The uterus was the size of a three to three and one half months pregnancy. The supposition was that she had aborted, or that there was a missed abortion. A frog test on January 5, 1962, was negative. On February 12, 1962, the uterus remained the same size and she reported passing dark blood and some clots. A curettage was performed on March 12, 1962.

She came to my office next on March 29. 1965. At this time she stated that her last menstrual period was near the end of November, 1964, and that it had been normal.

She was found to be four months pregnant. Blood serology and urinalysis were both negative. The blood pressure was 120/80. There were no abnormal findings on complete physical examination. Her only comment was that she did not think she was pregnant because she did not "feel" the same as she had during the other pregnancies.

Increased Amniotic Fluid

She was seen at intervals of four weeks. On May 24 a note was made that the abdomen was unusually large for the length of the pregnancy. The flanks were not bulging. Complaints were moderate; she mentioned slight pressure in the pelvis and slight difficulty in breathing when lying down.

On June 21 the blood pressure was 130/80. Breathing had become more difficult. There was pain in the lower chest which she described as the "ribs being very sore." She also complained of difficulty in eating, saying that any food seemed to cause distress. She was informed of the possibility of increased amniotic fluid and told to return in one week.

All symptoms were aggravated when she returned on June 28. She was so uncomfortable she could not lie down for sleep. Increased enlargement was very noticeable. The skin of the abdomen was shiny and there were no linea alba. Dr. C. A. Novy saw her in consultation.

Although no fetal parts could be palpated thru the abdomen, the head was palpated on vaginal examination. She said she still felt fetal movements though they were not as vigorous as during her previous pregnancies.

She was given Dyrenium® for one week. She and her husband were told that a Cesarean section might be advisable for her sake — but if it could be postponed a little longer, the baby would have a better chance of surviving.

She returned on July 6. All symptoms had worsened. She had lost three pounds, but with the continued increase in size of the abdomen, this loss was interpreted as a weight loss for her and not loss of fluid. She said she had not been able to sleep or eat for the past 10 days; she had even had

pain on drinking water. The diaphragm was high to percussion and did not move on inspiration. She also reported a bloody discharge two days before, several times during the day.

Blood pressure was 130/80. The urine contained one plus albumin. X-ray showed a normal bone formation of the fetus with a size to correspond with a seven months' gestation.

In consultation with Dr. Novy, the patient and her husband were told that a Cesarean section was advisable for the mother's sake and possibly for the infant's safety. Consent was given. Consent was also given for removal of the uterus if it seemed advisable.

A Cesarean section was performed on July 7. The uterus was first opened thru a small incision and the amniotic fluid siphoned off slowly. This may have meant some delay for the fetus, but oxygen was given immediately and the anesthetic was stopped for a minute or two. By measurement there was 12,400 ml of amniotic fluid.

The fluid was withdrawn slowly to prevent vascular collapse by sudden release of intra-abdominal pressure. Marked, dramatic improvement in the mother's breathing under anesthesia was noted when the uterus was half emptied. The fetus was delivered after 10 units of Pitocin® were given directly into the uterus. The mother was given Demerol® 75 mgm. and Ergotrate® grains 1/320 intramuscularly.

After delivery of the baby, the uterus was massaged gently. The anterior half contracted well but the posterior half did not. No tumors were palpated. With the mother in good condition and breathing well under anesthesia, the uterus was observed for a further four minutes. After a minute or two, the uterus became soft again throughout and did not contract anywhere. A supracervical hysterectomy was done.

The baby attempted to breathe but became cyanotic. The pharynx was cleared and mouth-to-mouth resuscitation was started. Spasmodic breathing occurred but the baby remained cyanotic. A catheter was inserted through a laryngoscope into the trachea. The heart continued to beat well and there were no murmurs, but cyanosis continued and the baby died after four hours and 38 minutes. Postmortem examination was not done. It is possible that death was due to hyaline membrane disease.

The mother, though very tired, did well after surgery and was discharged from the hospital on the seventh postoperative day.

Comment

Mild hydramnios is not rare. The amount of amniotic fluid usually continues to increase during the first six months with an average of 1,000 ml to 1,500 ml by the seventh month. Then the amount reduces somewhat to the time of labor as the baby gains weight. Amounts of 3,000 ml at delivery occur not too infrequently, but amounts of 5,000 ml or more are rare. As much as 30,000 ml has been reported. ◄

The Clinic
Garrett, Ind.

From *The Journal* 50 Years Ago

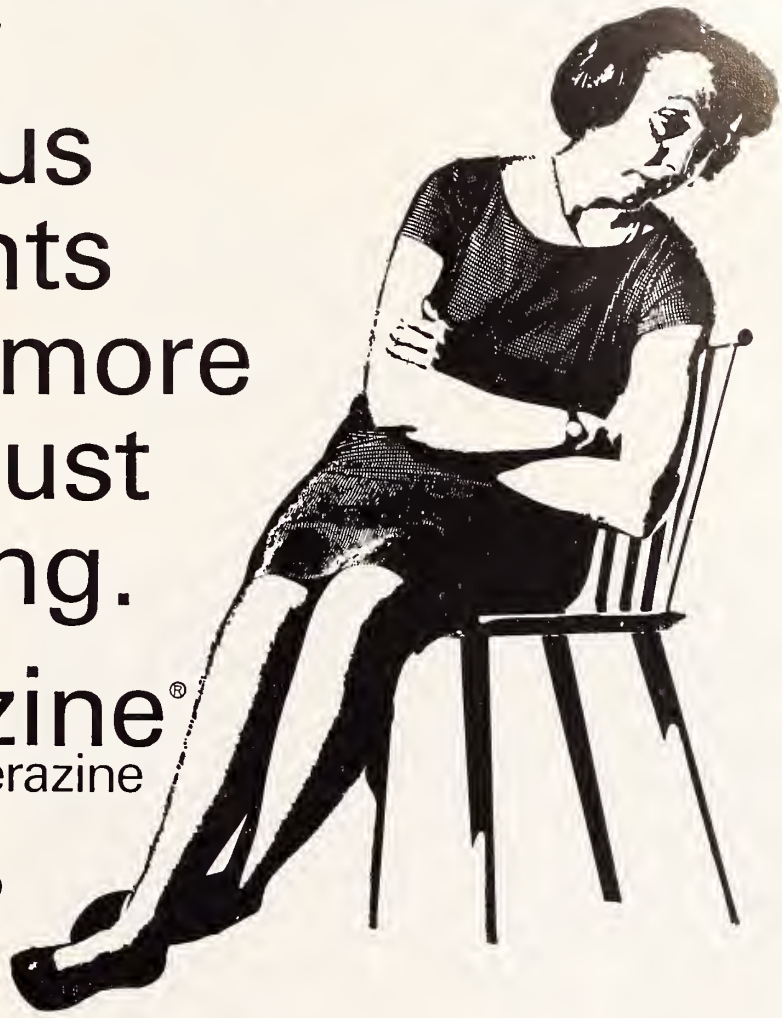
. . . When the patient has chronic pains in the upper part of the abdomen, we say it is gallstones, but the majority of cases operated on show gallbladder infection, just as in operations for appendicitis. We have found that fecal congestions cause the majority of cases of appendicitis instead of cherry seeds as was once thought. Do not gallstones cause more diseases of the gallbladder than diseases of the gallbladder cause stones?

When we operate we find that the gallstones have been there for years and years. It is not such an easy thing to diagnose gallstones or infection of the gallbladder. When your exploratory operation is made, then you know your disease is caused by that reason.

* * * *

But in many cases when we make a positive diagnosis of gallstones we find when we operate a gallbladder full of sand and no stones. In many cases we operate for other symptoms and find presented no semblance of the disease whatever. We find a gallbladder full of stones but the bladder perfectly healthy. As I said, do not we get the cart before the horse in laying the matter of gallstones at the door of an infected gallbladder? — Charles Stoltz, M.D., discussing Dr. W. H. Williams' paper on "Diseases of the Gallbladder and their Influence on Adjacent Organs," *JISMA*, July, 1916.

Many anxious patients need more than just calming.



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Sedative or muscle relaxant-type tranquilizers are often all that's needed for patients with temporary situational anxiety. But in the many patients whose anxiety presents a continuing problem these agents are limited by their generalized dulling effects.

'Stelazine' can attack anxiety directly without producing annoying dulling effects. On 'Stelazine', patients can react more normally to day-to-day stress yet remain alert, able to carry on their normal activities.

Contraindicated in comatose or greatly depressed states due to CNS depressants and in cases of existing blood dyscrasias, bone marrow depression and pre-existing liver damage. *Principal side effects,* usually dose related, may include mild skin reaction, dry mouth, insomnia, fatigue, drowsiness, dizziness and neuromuscular (extrapyramidal) reactions. Muscular weakness, anorexia, rash, lactation and blurred vision may also be observed. Blood dyscrasias and jaundice have been extremely rare. Use with caution in patients with impaired cardiovascular systems. Before prescribing, see SK&F product Prescribing Information.

SK&F Smith Kline & French Laboratories, Philadelphia

A very unusual foreign body of the axilla.

The "Four-on-the-Floor" Hazard

JAMES W. KILMAN, M.D.
WALTER JOLLY, M.D.
Indianapolis*
CHARLES GOODELL, M.D.†

THE recent popular revival of placing the gearshift on the floor of an automobile appears to have created a new health hazard. The installation of the gearshift on the floor in high speed automobiles with a four speed transmission is fondly referred to by the speed set and those still young at heart as "four-on-the-floor." We recently had the opportunity of treating a patient who was involved in an auto accident and suffered what we had rather freely termed the "four-on-the-floor" hazard.

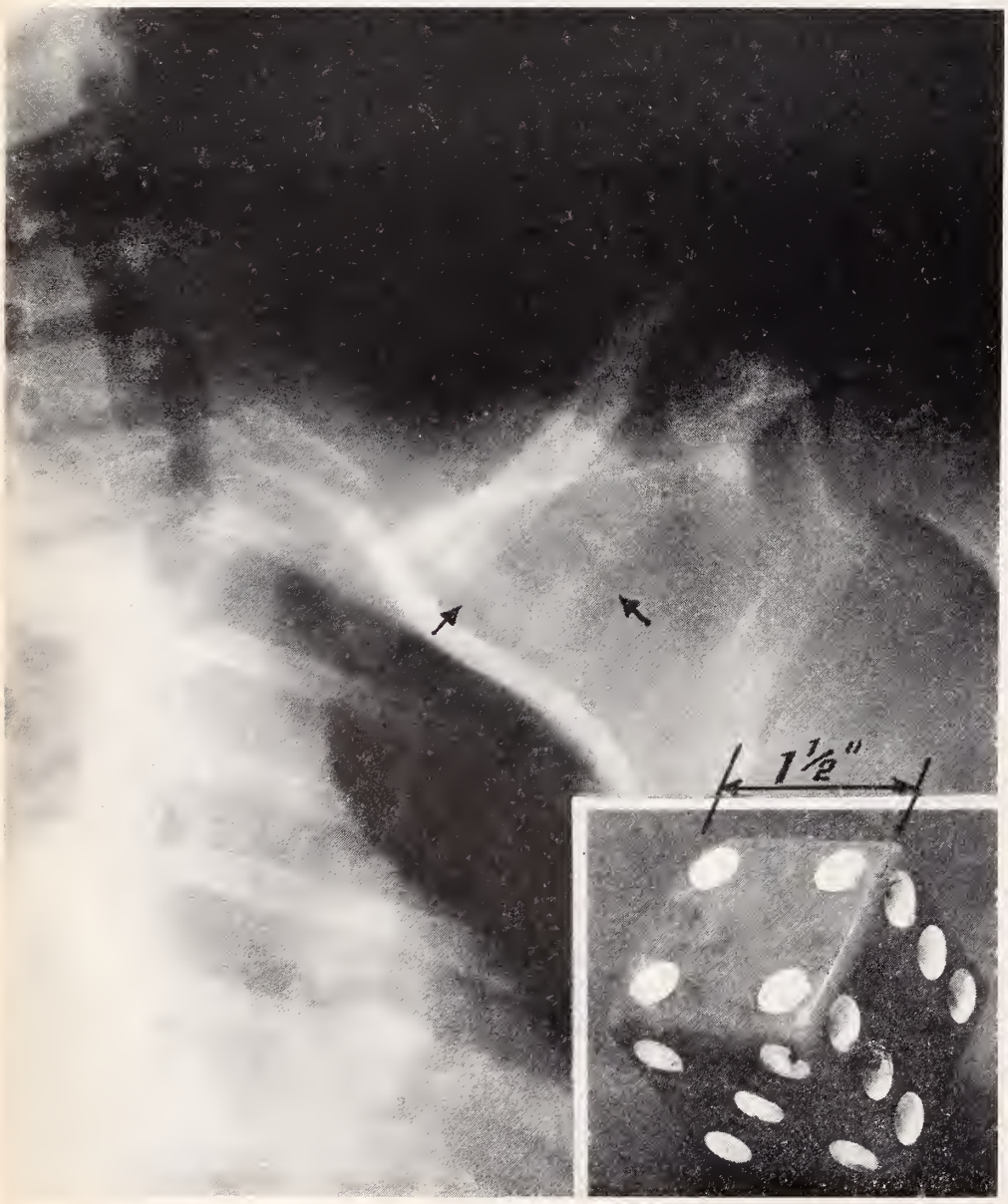


FIGURE 1
NOTE the cube-shaped density beneath the left clavicle.

Case Report

The patient was an 18-year-old white male who had been riding as a passenger in the front seat of a new model automobile with a floor placed gearshift. He did not have his seat belt fastened. The automobile was involved in a head-on collision. The boy's left axilla was impaled on the gearshift. He suffered no other injuries. He was removed from the automobile following the accident and taken to the emergency room of a nearby hospital. A wound of entry due to the gearshift was noted in the inferior posterior axillary triangle. The wound was explored and then closed with interrupted sutures. The wound healed well and he seemed to be recovering with no residual difficulties.

About three weeks following his initial injury, he developed paresthesias over the left ulnar nerve distribution. He was seen by his local physician who noted a pulsatile mass in the left supraclavicular fossa and some minimal weakness of motor function in his arm. He was then transferred to our hospital with the diagnosis of a traumatic subclavian aneurysm.

Physical examination revealed a healthy white male with no specific complaints. There was a pulsatile mass present in the left supraclavicular fossa. There was a slight bruit and thrill. All the pulses in the upper extremities were full and equal on both sides. Blood pressures were equal bilaterally. Neurological examination revealed minimal weakness of the left deltoid and triceps. There was slight

*From the Department of Surgery, Indiana University Medical Center, Indianapolis.
† 2810 Ethel Ave., Muncie, Ind.

weakness of the long digital flexors and extensors as well as the intrinsic muscles of the fingers and abductors of the thumb. There was no limitation of motion of the left extremity and there was no Horner's sign present. The wound of entry was well healed.

On x-ray study, (Figure 1) a cube-shaped density was noted beneath the left clavicle. The patient was again questioned concerning the accident. He stated that there was a device on the gearshift, a plastic cube made to resemble a die, and that to his knowledge it had not been found following the accident. An antegrade brachial arteriogram by the Seldinger technic via the left femoral artery revealed no involvement of the vessel (Figure 2).

The patient was taken to the operating room with the presumptive diagnosis of a foreign body in the left axilla adjacent to the brachial plexus. A supraclavicular incision was made. The lateral strap muscles were divided; dissection was carried down to the foreign body. The brachial plexus was retracted and the foreign body delivered from the wound. It was found to be a green plastic cube 1½ inches square (Figure 1 inset). Although a pseudomembrane had formed about the cube and there were bits of clothing in the wound, there was no sign of infection. No damage to the subclavian artery, subclavian vein, or brachial plexus was found. A drain was placed and the wound was closed.

A month following surgery, the patient had almost complete recovery of his minimal motor weakness and his paresthesias were gone. The wound was healed well.

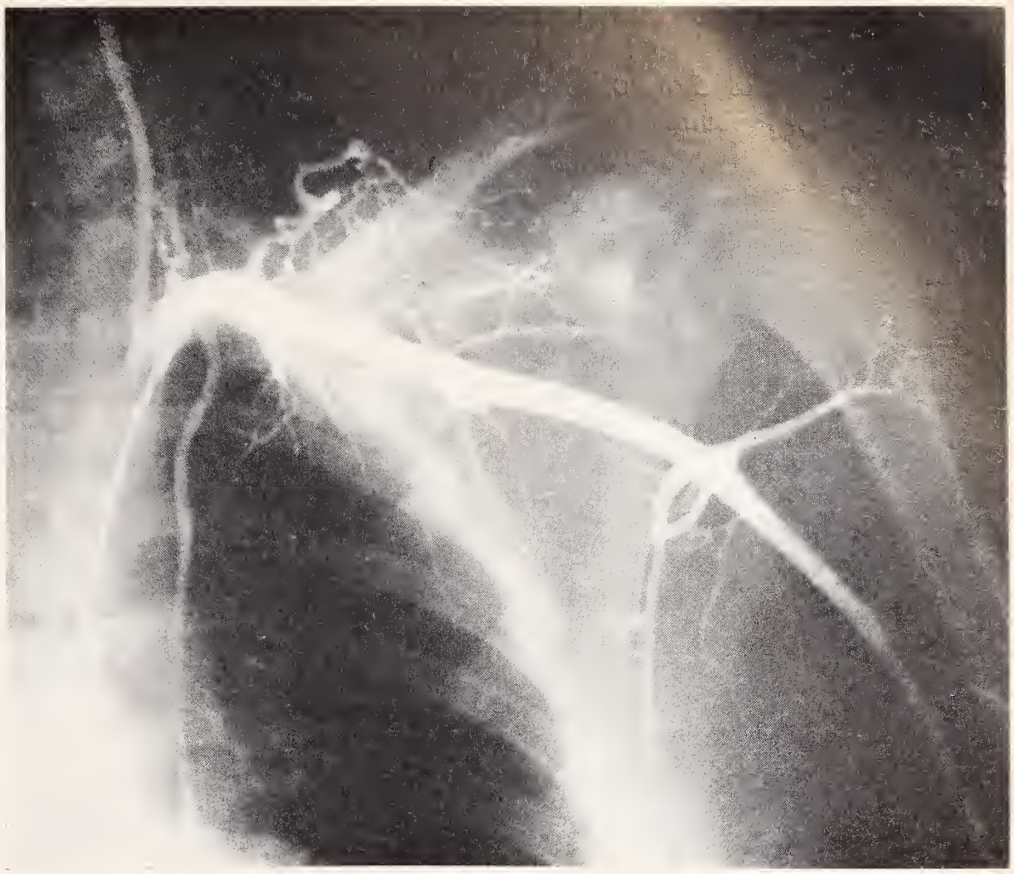


FIGURE 2
ANTEGRADE brachial arteriogram reveals no involvement of the vessel.

Summary

An unusual case of a penetrating foreign body which became lodged in the apex of the axilla is presented. It resulted from an automobile accident in which the knob of the handle of the floor gearshift was thrust into the passenger's axilla. The "four-on-the-floor" hazard constitutes a new aspect of an old problem in trauma. ◄

Drug Efficacy—Who's to Say?

The (new drug) law should be modified by the deletion of FDA responsibility for "efficacy." The final approbation or disapproval of a drug should be in the hands of the medical profession and not the FDA.

In addition, there are many officials of the FDA who should reassess their relationship to the pharmaceutical industry in the light of the sound philosophy that a successful democracy is more than a form of government; it is a behavior pattern which stems from the "Golden Rule."—John C. Krantz, Jr., Ph.D., in *Military Medicine,* 130:1, (Jan.), 1965.

One new cause and two cases are added to the list for differential diagnosis of pneumoperitoneum.

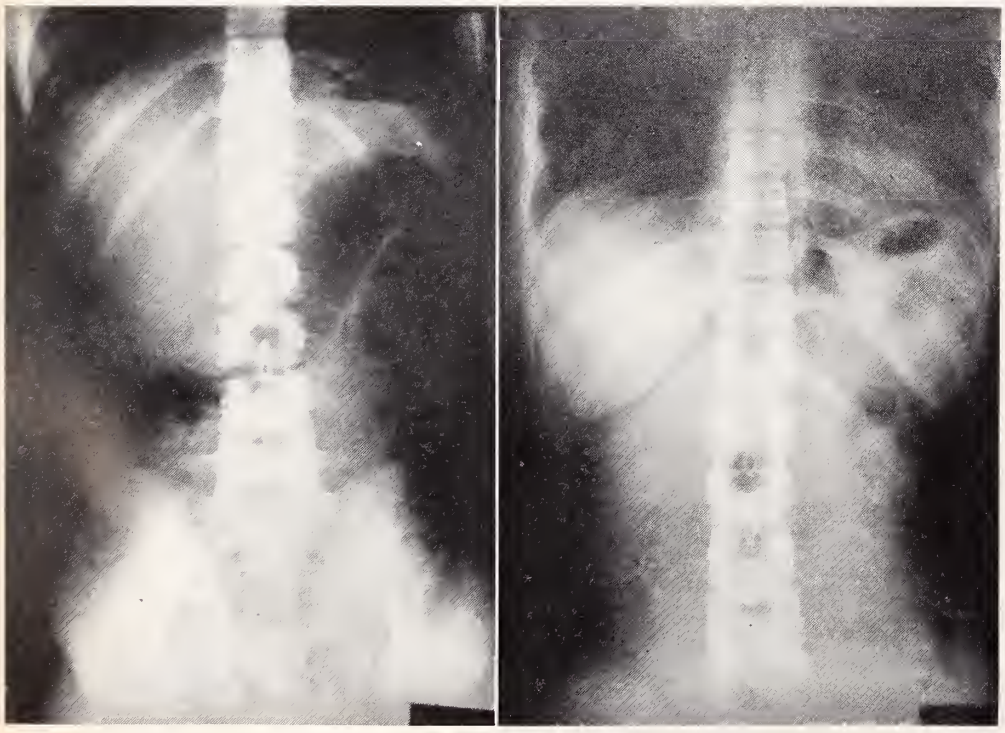
Salpingitis as a Cause of Pneumoperitoneum

GEORGE H. RAWLS, M.D.
Indianapolis

WHEN pneumoperitoneum is associated with clinical findings of an acute abdomen, the clinician usually makes a diagnosis of ruptured viscus. His impression is almost always correct, particularly if there is a history of previous x-ray findings suggestive of a duodenal ulcer. Moreover, he will usually be correct if there is a history of trauma.

Approximately 75% of cases of pneumoperitoneum in acute conditions of the abdomen are due to a perforated ulcer.[2] The other 25% are due to a variety of conditions, including: 1) subphrenic abscess with gas; 2) transposition of viscera; 3) hepatoptosis with colon between liver and diaphragm; 4) recent laparotomy; 5) perforated malignancy anywhere in the gastrointestinal tract; 6) perforated ulcer of bowel due to typhoid, tuberculosis, regional enteritis, ulcerative colitis or foreign body; 7) ruptured Meckel's diverticulum; 8) ruptured appendix; 9) ruptured diverticulum; 10) after trauma to rectum or sigmoid with enema tube or instrument; 11) blunt trauma; 12) pneumatosis cystoides intestinalis; 13) perforated bowel obstruction; 14) following therapeutic pneumothorax; 15) after gastroscopy; 16) after Rubin test; 17) after knee-chest position exercises in postpartum female; 18) after douche; and 19) intraperitoneal abscess with gas forming organisms.[1,2,3,4]

Recently two cases were encountered with pneumoperitoneum and clinical findings of an acute abdomen. At surgery acute salpingitis was found. No similar cases of this nature were found in the literature; therefore, it is felt that a report is indicated.



SUPINE (1-A) and upright (1-B) x-rays demonstrate free gas under the diaphragm (Case #1).

Case Report #1

A 12-year-old female was admitted to Methodist Hospital on August 23, 1964 with an obviously acute abdomen. According to the patient, about 5 o'clock on the day prior to admission, she tripped and fell on a broken curb and struck her abdomen. She developed excruciating, severe pain throughout the abdomen with nausea and vomiting. The pain persisted and she was brought to the hospital by her mother.

Her last menstrual period was just ending. The patient had been vomiting a green material and had crampy pains throughout the abdomen. A supine and upright x-ray (Figure 1-A and B) of the abdomen showed a considerable amount of free gas within the abdomen. Her white count was 12,700; two juveniles and 34 stabs; segmented 64%. There were 10 small and one large lymph. Hemoglobin on admission was 10.6 gms. Hematocrit reading was 32. VDRL was nonreactive; the urine was normal.

A Levin tube was inserted and 5% glucose in saline given intravenously. She had immediate surgery whereupon it was found that there was no free fluid within the peritoneal cavity. This was thought to be unusual. The small bowel was examined first from the ligament of Treitz to the ileocecal region. There was no evidence of perforation. There was extensive mensenteric adenitis, indicating some reaction. Incision

was then extended upward and the stomach inspected but there was no evidence of injury. The duodenum was mobilized by the Kocher maneuver and the duodenojejunal junction mobilized by incising the ligament of Treitz. The small bowel was run again.

The large bowel was examined with no evidence of injury. The sigmoid colon was examined and the left tube was found to be tremendously enlarged and obviously infected. There was some free pus in the pelvis. This was cultured. There was a cyst of Morgagni which was removed. Cultures were also taken of the vagina which appeared to have a perforated hymen. A creamy, pinkish discharge was noted.

Postoperatively, the patient continued to run a fever. She was placed on intravenous Chloromycetin® until cultures revealed the organism to be resistant to this antibiotic. Organisms grown out of the peritoneal fluid revealed streptococcus viridans, staphylococcus epidermidis coagulase negative, and aerobacter cloacae. Cultures from the vagina revealed the same organisms that were found in the abdominal cavity. She was placed on streptomycin gram 1 about the fifth postoperative day, since the organism was sensitive to it. She progressively improved and was discharged on the 14th postoperative day. She has been followed in the office and is doing well.

Case Report #2

A 29-year-old female was admitted to Methodist Hospital on September 5, 1962 because of acute abdominal symptoms. She had a history suggestive of peptic ulcer and pelvic inflammatory disease. However, the patient had free gas underneath the diaphragm and certainly evidence of a ruptured viscus, most likely peptic ulcer. Preoperatively, her hemoglobin was 13.8, hematocrit reading was 44, white count 7,150 with a slight shift to the left. Urinalysis was not remarkable. Amylase was 123. A previous upper GI series had demonstrated a duodenal ulcer.

The patient was explored immediately. There was no evidence of peptic ulceration, although there may have been a little scarring in the duodenum. There was certainly no fluid in the epigastric region. Attention was directed to the pelvis, where there were markedly distended fallopian tubes with pelvic peritonitis. This was aspirated and the patient placed on heavy doses of antibiotics. She made an uneventful recovery.

It is believed that both of these cases represent free intraperitoneal gas due to acute salpingitis caused by gas-forming organisms. Although a specific gas former was not identified in the second case, appropriate cultures for gas-forming bacilli were not run. In case number one, aerobacter cloacae were identified and most likely represent the source of the gas. It is noteworthy that the identical organisms were grown from exudate about the left fallopian tube and the vaginal discharge.

The diagnosis of salpingitis was not considered in either case. With the history of trauma in case number one, the age of the patient, the pneumoperitoneum and the evidence of generalized peritonitis, a diagnosis of a ruptured viscus secondary to blunt trauma was made. The hymen was broken and the mother suspected contact although the patient denied this. Of course, fecal contamination of the vagina with ascension to the fallopian tube is a possibility.

In the second case, the patient had been treated for an active duodenal ulcer which had been demonstrated radiologically and which had been intractable to medical treatment. She was admitted with evidence of generalized peritonitis and pneumoperitoneum. A perforated duodenal ulcer was suspected. However, there was no reaction in the upper abdomen. Findings were limited to both fallopian tubes which were tense and swollen with exudate oozing from the fimbriated ends.

Summary

Two cases of pelvic inflammatory disease masquerading as ruptured hollow viscera are presented. Pneumoperitoneum was thought to be due to gas-forming organisms in the exudate from the fallopian tubes. Thus one should consider salpingitis due to gas-forming organisms in the female who demonstrates an acute abdomen with pneumoperitoneum.

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BIBLIOGRAPHY

1. Britt, C. I., Christoforidis, A. M., Andrews, N. C.: Asymptomatic Spontaneous Pneumoperitoneum, *Amer. J. Surg.* 101:232-5, Feb., 1961.
2. Edwards, R. H., Foster, J. H.: Pneumoperitoneum in Perforated Duodenal Ulcer, *Amer. J. Surg.* 104:551-4, Oct., 1962.
3. Johnson, G.: Pneumoperitoneum in Acute Appendicitis, *Brit. J. Radiol.* 37:76-7, Jan., 1964.
4. Stubenbord, W. T., et al.: Perforative Appendicitis With Pneumoperitoneum, *New York J. Med.* 64:1125-7, May, 1964. ◄

The Reciprocity of Relationships

GORDON T. BROWN, M.D.
Indianapolis

THE function of the physician is to understand living to the end that it may be facilitated. In our profession we frequently consider the roles of those we serve. Sometimes, however, it behooves us to consider the role of the server and to assess the creeds, needs and deeds of those of us in the helping professions. What are the needs of the need-meeters? What do we receive as we give? What do we get out of it? What's in it for us?

But, it may be protested, in these altruistic, selfless and giving professions, is it not a paradox to consider the needs of the giver? Not so — nature maintains an equilibrium and there is a homeostasis and balance in human relationships. We derive from a relationship the equivalent of what we put into it or it breaks down and decompensates. When, in any relationship, one is not deriving from it the equivalent of what he is investing in it, the relationship becomes distorted or terminates.

If a boy is hired to cut the grass and he doesn't cut it, you quit paying him. If you love someone and he stops loving you, your love ceases or it may be changed to hostility and the relationship assumes a new equilibrium. If some balance is not maintained, the structure collapses. Like a teeter-totter, relationships have to be a mutual transaction or they simply do not work. For the sadistic person there is a masochist; for the passive-dependent person, there is someone to dominate and control him; for the voyeuristic peeping-tom there is the exhibitionist. In most human relationships, value is received for value given. What do we receive in our giving roles?

Power over People

A common need is to be omnipotent — to play God — to control and manipulate. In doing things for others, we exercise power over people. This may be self-aggrandizement in which the power need of the giver enslaves the receiver. Scripture tells us that "the Lord loveth a cheerful giver," but it may be suggested that the giver loveth a cheerful receiver. We seem to have to be needed—to be loved and wanted. One example of this may be the long waiting lists many clinics and health agencies maintain. In an effort to assess the accepted lengthy waiting lists at one clinic, it was proposed that one factor operating might be this very need to be wanted and sought after. When this was confronted and handled more realistically, the waiting lists were soon eliminated.

Another need of the need-meeters may be to assuage one's own existential or neurotic guilt by helping others. The more theological may call this atonement. One may kid and delude himself regarding his own motivation but there are few people entering the helping professions without some elements of guilt. It is as if we felt unconsciously that we caused the sickness and we must therefore undo it. This sense of guilt and need for atonement may be one reason some in our professions are willing to work for such degrading salaries. It may be observed that, in our efforts to relieve our sense of guilt, we attempt to share it and dilute it in the plethora of conferences, staff meetings, supervisory sessions and similar confessionals. In these, we may attempt to abdicate our responsibility to the group or to various consultants, supervisors and boards of directors. Actually, I suspect, the majority of staff conferences and conventions represent an appalling waste of time and resemble nothing quite so much as an adolescent mutual masturbation party. In gathering together and confessing or performing the same rite collectively, each feels better about doing it individually.

Another factor operating in our creeds, needs and deeds is that in meeting people's dependency needs, we may be meeting vicariously our own dependency needs — our own needs to be nurtured, as well as to nurture. In this we seem to visualize ourselves as big-breasted mother figures. We identify with the underdog and also with the underdog's protector. There is the possibility, however, that in meeting the needs of the underdog, we may unwittingly perpetuate his dependent state.

In working for a period of time as a physician in a rural southern highland area, I was surprised to observe that many of the missionary-type personnel in the area were actually opposed to any progress in the form of roads, schools, industries and hospitals. There appeared to be a strong need to keep the "natives" in a dependent, primitive, infantile state. The fact that this demeaned the natives did not seem to occur to many of them. For the populace to have become more mature and independent would have undermined the reasons for the missionaries' presence.

Indeterminate Infantility

I propose that we should not attempt to play God by taking over the responsibility of another. Confronting the responsibility of one's own existence represents one of the few ways of defining one's being. The parent who continues to do everything for his child often tells me that he does this out of love. It may, in fact, be the most hostile thing he could perpetrate

upon the child, for it encourages him to remain forever an infant. We cannot do very much for a person unless we can do something in the person. It is demeaning to do for a person what he can and should do for himself and unless motivation for betterment can be stimulated from within, we really do not accomplish very much. Maturity, unfortunately, is not like a shot of penicillin that can be administered whether the person wills it or not. If a person does not want to be helped emotionally, he cannot be helped. Without some care and concern for himself, a person is indeed a lost soul. If pride goeth before a fall, it also goeth before a rise. If a person does not have some pride in himself and a healthy self-respect — he cannot respect others.

I recently saw an inmate at a penal institution who informed me that several years previously he had been treated in a child guidance clinic. Upon inquiring of what his therapy consisted, he responded, "I don't know, doc, all I know is they just accepted the hell out of me." They may have accepted the hell out of him, but obviously they had failed to challenge him to confront the responsibility of his own being and destiny. Insofar as they had failed in this, they failed in their mission of helping him become a person. Someone incisively described the three attributes of a man as — consciousness, freedom and responsibility.

People inevitably become hostile to those upon whom they are dependent. This is often true because the relationship is not a reciprocal one, and in these situations the helper experiences the paradox of hostility from those he is helping. Nevertheless, the dictum is ancient of biting the hand that feeds one. We may anticipate hostility on the part of the agency toward the United Fund that supports it. We resent those from whom we borrow money. And the parents of the 40-year-old adolescent who still lives at home under their protection have to expect that he will hate them.

As obvious examples of the appropriateness of the reciprocity of relationships; when one goes into a store to buy some shoes he pays his money and takes his shoes. Similarly with a restaurant, a school, a doctor's office, a marriage, an automobile agency or a whore house. Value must be received and given or the relationship is disrupted. Therefore, we in the helping professions also must be deriving some equivalent satisfaction from the relationships in which we work. Do not give anything away free — and if anyone offers something for free, turn it down — it's a fraud. Any relationship that is not reciprocal is a fraudulent relationship. It does not come out even. Something of value is not obtained cheaply.

The "Unhelpable" Helpless

Relative to the question of motivation, I would suggest an aside regarding free enterprise and the profit motive of self-interest. Some may consider this anathema to our professions — and yet where value is given and profit received, it is more likely that the relationship may be a healthy and a productive one.

During some medical mission efforts in a rural mountain area, the suggestion was proposed that the patients might be required to pay appropriately for their own medical care, in an effort to enhance the personal motivation of the helper and the helped. Despite the obvious fact that we value more those things in which we make a real investment, this was declined.

It was later suggested to the local welfare council that it would make a fascinating research project in some of the health and welfare agencies to conduct a work-output study and reimburse the staff members proportionate to the work units performed. I suspect that this would both increase the work and decrease the budget. This was also declined, however, as an unseemly suggestion.

It is true of many of us in our professions that we want to do too much. We overcommit ourselves unrealistically to those we attempt to help. Again, we identify with the underdog. I am not sure but that the theme of the story of the prodigal son might not be that people need the sin and guilt of the prodigal in order to justify their forgiveness, benevolence and nurturance. Insofar as this be true, it can only detract from the dignity and self-respect of our professions. In this, we are often guilty of helping people perpetuate personal and family patterns of social irresponsibility and tacitly discouraging them from maturely embracing the responsibility of their own being.

This may be considered heresy, but incontrovertable facts would seem to indicate that some people are not worth helping because they are unhelpable. I suggest the possibility that investing countless hours and money in impossible "hard-core" cases may be fruitlessly wasteful of staff and finances and may contribute to a health agency's failure to meet its broader responsibilities to the helpable community. In most areas of living it is a reality of life that not everyone can be helped. The surgeon must face this fact every day. I wonder why, in some dimensions we are so reluctant to face this same fact — or does our own guilt prohibit this? The realities and unrealities of the helping roles should be faced, and in a relationship that is not reciprocal and is not in balance, only frustration and dissolution can result. While in favor of helping the helpless, I am not in favor of needlessly perpetuating their helplessness.

Within the limitations of society and of his own destiny, man should be free to be what he will, and I am inclined to believe that most men are. Perhaps, after all, man should get what he deserves. Most patients, despite the fact that they come with general or specific dissatisfactions, materially contribute to what they are emotionally, including their problems. Excluding very few conditions, they are the masters of their fates.

Reciprocal Relationships

Of many institutional inmates seen during the past years, all complained

of their situation, yet all had obviously made certain choices to determine their present life. In effect, society treated them the way they demanded. So the relationship was reciprocal. Many patients complain of the way people treat them, yet as their approach to people is explored it becomes obvious that they give others no choice but to treat them in these very ways, about which they complain. These relationships are, therefore, reciprocal.

I recall an attractive girl who objected that practically every man she met tried to seduce her. She seemed quite sincere and this appeared something of a mystery until I had occasion to observe her functioning socially and it was obvious that she invited this response from others. This too, was reciprocal. Many alcoholics' wives uniformly complain of their husbands' weaknesses, dependency and lack of moral fiber. Yet in almost all these cases, the wives have fostered this dependency and I have seen several such people who, in choosing their subsequent mates, have selected someone cut from precisely the same cloth. It is inevitable that they must get something out of such a relationship. This also, then is reciprocal.

Many fat people complain that they are not sexually attractive to others — yet they continue to eat their way into obesity. Many people complain that they cannot obtain good jobs or make more money — yet they are unwilling to pursue the training and education available to them that would make this possible.

In summary, the point is essentially that we be aware of the fullness of our relationships with those we attempt to help — that we be conscious of our effect upon our patients — and of their impact upon us.

The more we are attuned to the mutuality of these helping relationships, the more objective and therapeutic they will be.

The more we are aware and in control of our own subjective needs, the less they will contaminate our professional relationships.

The more we know ourselves, the better we can assist others to become selves.

The more fully we understand living, the more richly can we facilitate it. ◄

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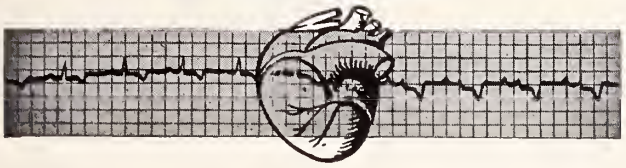
Drug Safety—Who's Responsible?

Government, the physician, and the pharmaceutical industry must join forces to reduce injury from adverse drug reactions. It is industry's responsibility to continue with the development of safer and more effective drugs.

It is the responsibility of the physician to use drugs with discretion and to abstain from using potent and hazardous drugs for trivial conditions. It is the government's responsibility, with its virtually unlimited funds and resources, to continuously review and survey adverse experience gained with drugs from all sources and to bring these facts before physicians preferably through already organized channels of medical communication.

The government further has a responsibility to remove overly hazardous drugs from the market when usefulness does not balance off against hazard, but it must not use this authority in an arbitrary and capricious manner. The evaluation of drugs for safety is a most difficult and complex matter, and no simple formula can be devised to arrive at a conclusive opinion.—Joseph F. Sadusk, Jr., M.D., to American College of Physicians, New York, April 19, 1966.

Electrocardiogram
of the month



Presented as a regular feature of The JOURNAL, Electrocardiogram of the Month is a series of short talks on cardiovascular diagnosis and treatment, edited by the staff of the Krannert Heart Research Institute, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis.

Paroxysmal Atrial Tachycardia (PAT) With Block in a Case of Wolff-Parkinson-White Syndrome (6)

CHARLES FISCH, M.D.
Indianapolis

THIS is an unusual case of Wolff-Parkinson-White syndrome complicated by PAT with block. Starting with strip C (Figure 1), the dominant rhythm is a PAT with a rate of 150 and a 2:1 AV block. The first four QRS complexes demonstrate the W-P-W. The P-R is relatively short, three is an absence of a Q wave, the slur of the upstroke (△ wave) is clearly evident. Beginning with the fifth QRS, the conduction is normalized. The P-R is longer and the slur on the upstroke of the QRS (△ wave) is no longer present. Such QRS changes are pathognomonic of W-P-W as it changes from abnormal conduction via an accessory pathway to conduction through the normal AV pathway.

The V1 lead in A shows W-P-W with PAT and 1:1 conduction on the left and 2:1 conduction on the right. Lead V5 demonstrates a predominant 1:1 conduction interrupted on three occasions by 2:1 conduction. The QRS following a 2:1 block (longer recovery period) are less aberrant than the QRS recorded during 1:1 conduction.

The QRS complexes in B are "normalized" (conduction is through the normal pathway) and the dominant rhythm is a PAT with 2:1 AV block (1, V1). Atrial arrest and AV nodal rhythm is seen in leads 2 and part of lead V2. ◄

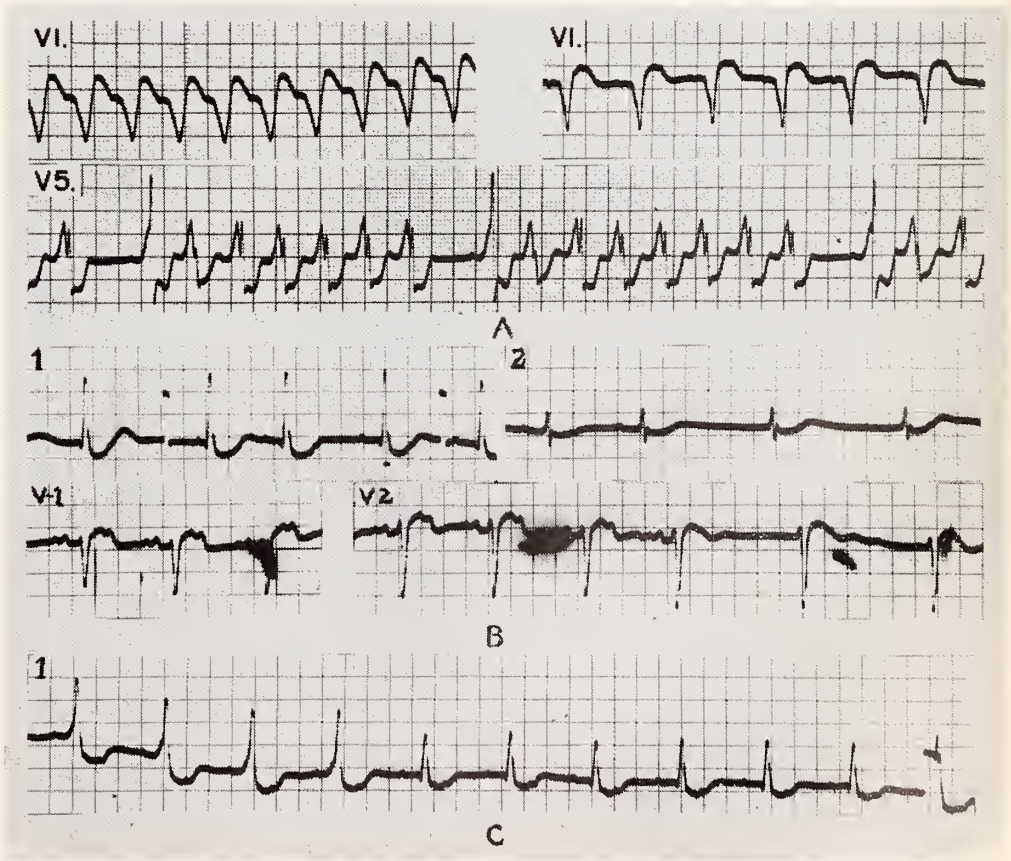


FIGURE 1
PAT with 1:1 and 2:1 block in a case of W-P-W.

X-RAY CONFERENCE

Presented as a regular feature of *The Journal*, X-ray Conference is a series of short talks on procedure and radiologic diagnosis, edited by Erich K. Lang, M.D.

Suburethral Diverticulum in the Female

ERICH K. LANG, M.D.
*Indianapolis**

A 44-year-old Negress was referred for x-rays because of persistent pyuria, hesitancy, dysuria, dyspareunia, frequency, nocturia unresponsive to Gantrisin®, Furadantin® and Chloromycetin® and bedwetting at coitus. Vaginal examination revealed a slightly tender one-and-one-half-inch long mass in the posterior urethra. Manipulation resulted in expression of pus from the urethra.

A positive pressure urethrogram (Figure 1) demonstrated a compound diverticulum arising from the posterior female urethra. The narrow neck was readily demonstrated.

After confirmation of the diagnosis by urethroscopy, surgical excision was accomplished. The patient had an uneventful recovery and complete cessation of symptoms followed the surgical correction.

Discussion

Suburethral diverticula in the female appears to have a much higher actual incidence rate than most reported series would indicate. It is felt that in many instances undiagnosed suburethral diverticula are responsible for persistent pyuria, bacilluria, dysuria, frequency and drug-resistant nocturia in the female. Although the urethra is the most accessible portion of the female genitourinary system, it is an area infrequently examined by urethroscopy and roentgenographic examination.

The introduction of positive pressure urethrography[1] has increased our ability to diagnose this elusive disease entity.

Technic

A special double balloon catheter (Lang-Davis catheter) has been devised for positive pressure urethrography. The proximal balloon is inflated and drawn against the internal sphincter with the balloon lodged in the bladder. The second balloon is then inflated and pressed against the external meatus, thus tamponading the outflow tract. Traction is maintained on the vesical balloon until the inflation of the distal sliding balloon is completed, and it is locked in position. Four to six ccs. of contrast material are then gradually injected through an opening in the central portion of the catheter, with the injection commencing prior to complete occlusion of the external meatus by the second balloon to allow flushing of air and other debris from the female urethra. The pressure exerted by the final injection of contrast material after the balloons are locked in position will effect filling of any diverticula arising from the now tamponaded urethra. Films are obtained in AP and oblique positions but particularly after removal of the catheter. This delayed film ascertains the capability of the diverticulum to retain dye which is considered a valuable prognostic sign. Only patients who retain dye after removal of the catheter are considered candidates for surgery. Thixokon, a thickened sodium azetrizoate solution, is favored as contrast material.

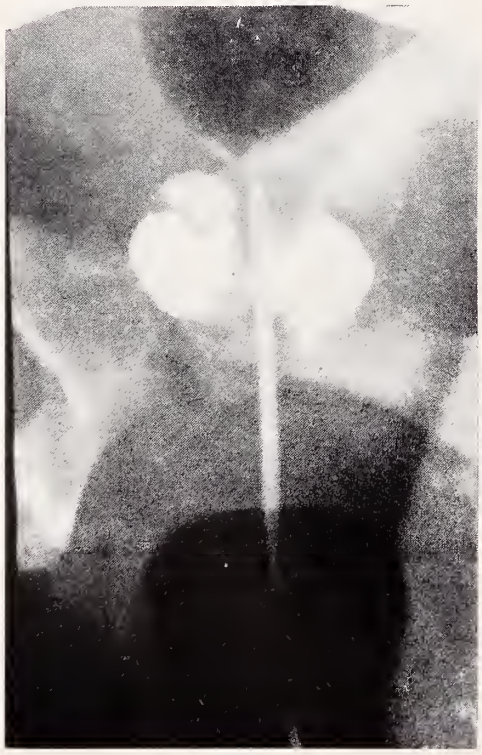


FIGURE 1
NOTE the large and compound suburethral diverticulum with the neck arising from the posterior urethra. The vesical and external balloon are inflated and locked in position.

*Department of Radiology, Methodist Hospital, Indianapolis.

Positive pressure urethrography is a valuable and simple roentgenographic technic in the diagnosis of sometimes elusive suburethral diverticula. The method is simple and easily performed, utilizing a double balloon catheter (Lang-Davis catheter).

REFERENCES

1. Lang, E. K., Davis, H. J.: Positive Pressure Urethrography: A Roentgenographic Diagnostic Method for Urethral Diverticula in the Female, *Radiol.* 72:401-405, 1959.

Addendum

Since the publication of the article "Renal Infarct" in the April issue of the *Journal of the Indiana State Medical Association*, several letters querying the frequency of occurrence of renal infarcts have been received.

The statement that renal infarcts rate second in patients presenting with hematuria and pain is related to a series collected from patients seen in an x-ray department. However, the most common causes for hematuria would not necessitate radiographic examinations, and hence this entire group of patients is excluded from this particular series.

In the female, by far the most common cause of hematuria is hemorrhagic cystitis. Carcinoma of the bladder and calculi are listed as second and third most common causes. In the male, by far the most common cause for hematuria is prostatic hypertrophy and bleeding from the prostate on basis of other etiology. Carcinoma of the bladder, ureteral calculi, glomerulonephritis and renal infarct follow as other frequent causes in most large series.

The statement in the article on "Renal Infarct" refers to a select group of patients seen by radiologists for consultation and diagnostic studies, investigating hematuria and hence represents a relatively small group of some 30% of all patients admitted with hematuria such as would be seen in the office of the urologist.

Erich K. Lang, M.D.

ASTHMA: IMMUNOLOGICAL AND NON-IMMUNOLOGICAL

One of a series of case reports illustrating the differential diagnosis in patients with symptoms of asthma.

IRVIN CAPLIN, M.D.

JOHN T. HAYNES, M.D.

Indianapolis

A 64-year-old man was seen in consultation for asthma of five years duration. He had a "cigarette cough" of 15 years duration, and had averaged smoking one package of cigarettes daily for almost 50 years. His wheezing was worse in the early morning. During the past month, his shortness of breath had steadily increased. He was afraid to lie down at night because of severe nocturnal dyspnea which awakened him from sleep and forced him out of bed in terror. He had been taking Amesec® for relief. His dyspnea and weakness were becoming progressively more severe.

FIGURE 1
ENLARGED heart and an edema of both lower lung fields is evident.

Family history was negative for allergic disease. There was no cause-and-effect relationship to incriminate allergic disease.

Physical examination revealed a stocky man of 64 with marked shortness of breath. The eyeballs were soft. Blood pressure was 170/100. The neck veins were distended in the sitting position. A grade #3 systolic murmur was heard over the entire precordium. There was a tambour aortic second sound. Dullness and crepitant rales were present in both lung bases. The liver margin was down four finger breadths below the costal margin. There was a 2+ pitting edema of the ankles. The femoral pulses were weak. Popliteal, dorsalis pedis and posterior tibial pulses were absent bilaterally.

Pertinent laboratory data revealed a 3+ glycosuria and fasting blood sugar of 350 mgm %. A sputum smear revealed 33% eosinophils. A chest x-ray (Figure 1) revealed an enlarged heart, passive congestion of the lungs and an elevated right-leaf of the diaphragm from the pressure of an enlarged liver. A cardiogram revealed a sinus tachycardia (rate 120), semi-horizontal heart, intraventricular conduction defect, ventricular premature contractions, depressed ST segments and abnormal T waves. Skin tests were negative, with the exception of equivocal reactions to dust, dog hair and feathers.

The patient was treated with digitalis, diuretics, diet and insulin. He quit smoking and the wheezing he had had for five years disappeared. He was able to return to work as a salesman in a department store.

This patient again reveals that dyspnea which starts in the elderly is usually not allergic in origin. Was his wheezing a "smoker's asthma" from chemical irritation or a "cardiac asthma" from left-sided heart failure? Did both contribute to his wheezing? Again, we have an interplay of many processes: diabetes, cardiac failure, peripheral vascular disease and possible smoker's asthma were all present in the same individual. And yet, he was seen in consultation for care of allergic asthma which he did not have. The presence of eosinophils in nasal secretion and sputum does not necessarily indicate allergic disease. ◄

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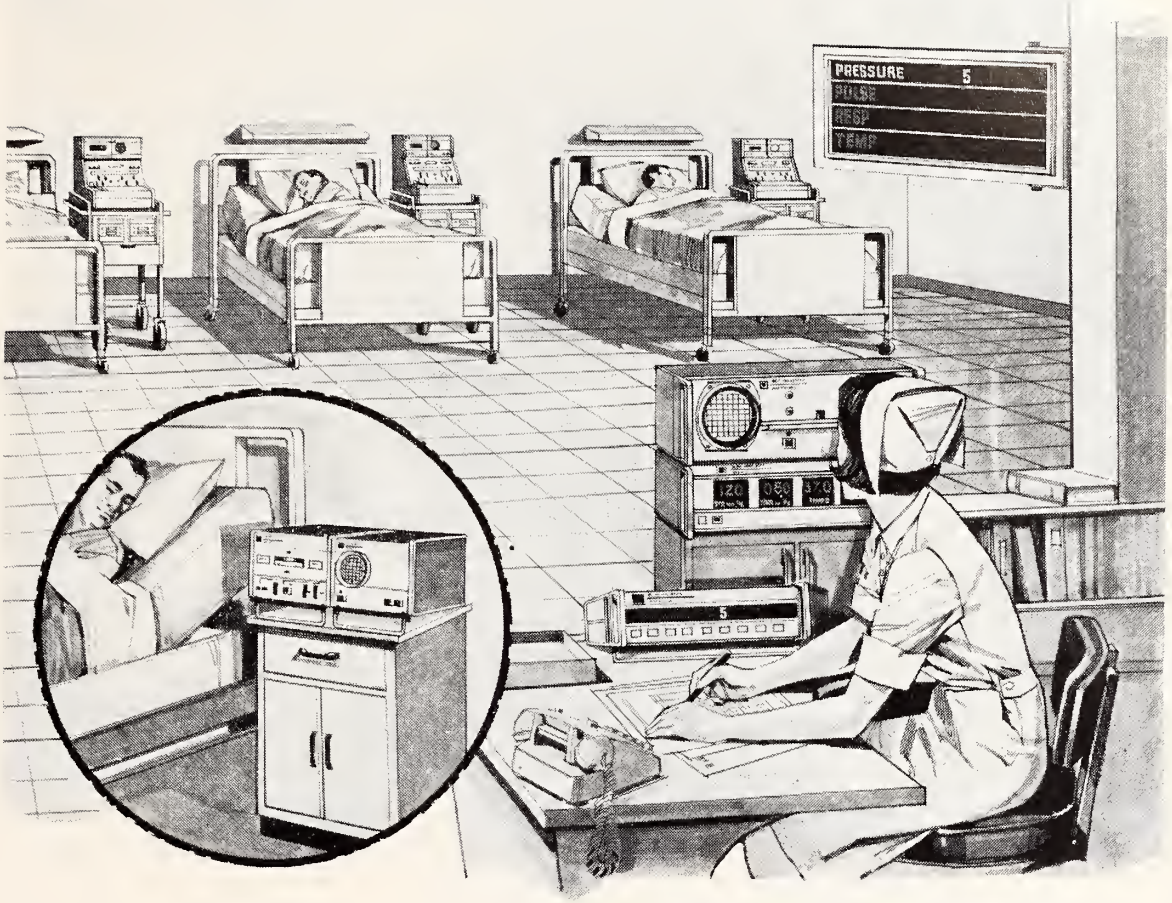

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Path-finder
PUBLISHED UNDER THE AUSPICES OF THE INDIANA ASSOCIATION OF PATHOLOGISTS

This series is intended to emphasize the importance of judicious selection and proper interpretation of newer laboratory procedures as applied to differential diagnosis of various diseases. It is edited by Leon L. Blum, M.D., Terre Haute.

Differential Diagnosis of the Month:

LYMPHOCYTOSIS

ISABELLE BUEHL, M.D.
*Indianapolis**

Clinical data:	A 10-year-old girl was admitted to the hospital with a history of increasing fatigue, chills, fever and sore throat of 1 week's duration. Shortly after the beginning of these symptoms, she noticed the appearance of "lumps" in the right side of her neck.
Physical examination:	Enlarged, slightly tender lymph nodes in the supraclavicular and posterior cervical regions and an enlarged spleen palpable two cm. below the left costal margin. The liver was not palpable.
Laboratory data:	Hematocrit Reading: 42, hemoglobin: 13.9. Total white blood count: 21,000/mm^3, differential: adult polys 8%, bands 7%, lymphocytes 80% and large monocytes 5%; 60% of the lymphocytes were atypical. A few contained one or two nucleoli.
Consultation note:	The pathologist was consulted concerning the possibility of lymphocytic leukemia. With the presence of lymphocytosis, 60% of which were atypical, the pathologist suggested the tentative diagnosis of infectious mononucleosis and recommended the performance of a heterophile antibody test. The following results were obtained: Titre of presumptive test 1:896. Titre after guinea pig absorption 1:224. Titre after beef red cell absorption 0.
Interpretation:	Lymphocytosis with presence of atypical lymphocytes and a positive heterophile antibody test establishes the diagnosis of infectious mononucleosis. The abnormal lymphocytes are given various names: "virocytes, atypical lymphocytes, and leukocytoid lymphocytes." Downey classified these abnormal lymphocytes into three types: Type I lymphocyte has an oval, kidney-shaped or slightly lobulated nucleus and vacuolated non-granular cytoplasm. The nuclear chromatin forms a coarse

* Department of Pathology, Indiana University Medical Center.

network of strands and masses. This is the type most frequently seen in infectious mononucleosis. Type II cells are larger than Type I. Their cytoplasm is not vacuolated and the nuclear chromatin is not condensed. Type III cells may be immature and have one or two nucleoli and a vacuolated basophilic cytoplasm or may have the appearance of plasma cells. Type III cells may be confused with leukemia. These abnormal lymphocytes are not specific and may be seen especially in viral and liver diseases. The total leukocyte count is usually increased but may be normal or even decreased. The rise in lymphocytes usually begins on the fourth or fifth day but may be as late as 12 to 14 days. The hematologic changes usually persist for one to two months. A bone marrow examination is sometimes requested to exclude leukemia and will reveal the presence of a lymphocytosis with atypical lymphocytes with the same morphology as those in the peripheral blood. A bone marrow examination, however, is not usually indicated in these patients.

The heterophile antibody or Paul-Bunnell test is based on the observation that patients with infectious mononucleosis have an elevated titre for sheep erythrocytes which is called the presumptive test for infectious mononucleosis. This test is not specific. Elevated titres may be seen in serum disease and infections of the respiratory system. Low titres usually less than 1:112 may be present in normal people. Patients with infectious mononucleosis usually have a titre of 1:224 or higher. If the presumptive test is positive, then the differential test should be performed. The principle of the differential test is that absorption of serum with suspension of a Forssman antigen (guinea pig or horse kidney) removes the anti-sheep agglutinins in the serum of patients with infections and serum disease but not in the serum of patients with infectious mononucleosis. The absorption with beef red cells removes the anti-sheep agglutinins in infectious mononucleosis. Anti-sheep agglutinins in conditions other than infectious mononucleosis may or may not be absorbed by beef cells. In order for the change in titre to be significant, there must be a drop of at least four tube dilutions. A drop of three tubes or less is not significant.

Usually the heterophile antibody test is positive when the patient presents symptoms but may be negative for as long as three weeks.

The symptoms, physical findings, and total white count may simulate leukemia. Examination of the peripheral blood smear and a positive heterophile antibody test should point to the correct diagnosis of infectious mononucleosis.

Recently a new rapid slide test for detecting infectious mononucleosis employing specially-treated, standardized erythrocytes has been introduced. Some laboratories report a high degree of specificity and accuracy. Results may be read after two minutes. The place of this new test in differential diagnosis of infectious mononucleosis remains to be established.

Follow-up: The patient was treated symptomatically and was well after two weeks.

A letter of advice from an orthopedic surgeon to his son and daughter-in-law on the occasion of an injury to one of them by hyperextension of the neck during an auto accident.

"Whiplash"

My dear children:

First of all let me say how sorry I am to know that you have been involved in an accident. It is always an uncomfortable experience, if not one more serious physically; a disturbing one for domestic life and activities, and one always carries a little bit of difficulty from any experience one has, and this is probably no exception.

As I tried to say by phone, if the x-rays of your neck show no bony injury or joint dislocation, then your injury has consisted of a stretching and possible minimal tearing of the "soft tissues," that is the muscles and the ligaments in the neck and shoulder area.

This condition will all but completely restore itself to normal, the residual difficulties being generally negligible. However, while the muscles and ligaments are in the process of restoring themselves, which takes several weeks, their ability to balance your head on the end of your spine and lift your shoulders to the normal height, will be uncomfortable and impaired.

Thus, these injured parts require much more rest than would the same structures in an uninjured state. We believe the proper program is to say that from the onset you are largely in bed, the weight of the head supported on your pillow. The head should be changed in its position frequently, even rolled gently from side to side so as to actually gently move the muscles and ligaments that have been hurt. This keeps them from developing a decided tightness, stiffness or even some shortening.

Erectness a Necessity

However, we believe they should be given some work, in keeping with their ability to do so. Therefore patients are asked to get up to the toilet, possibly to eat a meal, and frequently to walk about the house, the yard or on the street. When the patient is up, a general erectness of the total body, including the head and neck and a general lifting of the shoulders should be maintained. A "slumped" posture should be definitely avoided.

At the onset, probably while you are reading this letter, you would spend most of your time in bed, and comparatively little of it up and about. Progressively, you will be in bed less, and on your feet more, but you should never resist a return to bed when the neck has become tight, uncomfortable, or you catch your posture slumping from your excellent normal posture.

The duration of symptoms from this condition is largely related to the actual degree of the injury sustained, but also related to the protective care the patient gives to aiding and abetting nature in repair, and the avoidance of an attitude of heroism which permits the patient to be up longer, develop more soreness, stiffness and tightness than is reasonable. Thus you may look to a few days, a few weeks, even a few months of certain measures of protection to your neck.

Incidentally, this will indicate that you will need household help in cooking, care of your children, cleaning and many other things which you would normally do. It would also mean a total arrest of your social activities for the time being, and the resuming of any of them only when you can lie down and rest your neck and shoulder areas on their demand for rest.

Nature Best Healer

We think that the wearing of a rigid collar about the neck is unwise. It tends to push down on the shoulders as much as it lifts the head, which is bad. It also tends to make the neck more rigid, whereas the neck and its musculature likes to be flexible and frequently moved. We also think that traction on the neck as seated in a chair in a doorway is a delusion rather than any form of actual treatment. You will see that we rely on nature for the cure which is exactly where all cures come from. You will see that we believe most people get into trouble when they do not go along with the natural repairative processes of the body.

There is no occasion whatever to be at all worried, excited and certainly not neurotic about the kind of injury you have had. It is an uncomfortable, undesired and very tedious sort of experience, yet one in which recovery is as attainable as in any sort of comparatively simple injury.

If you need any professional help it should be from a competent orthopedist, possibly the chief of the orthopedic section in the hospital which you most value in your community.

I believe you mentioned you had made contact with an attorney. The vast majority of attorneys are respectable and honorable citizens and per-

form functions for us we could never perform for ourselves. However, there are some attorneys who like to keep people sick, enjoy having people crippled to some degree and seem to resent patients who follow good instructions and recover. It would be my advice that you ask your attorney to obtain from whoever seems responsible for your accident, if you are not yourself, all of the expenses to which you have been put, the car, the help, any legitimate expense involved, plus his fee. You have no need to make any money out of this accident. Your entire concern is your own personal recovery and the resuming of your full life. I only add this comment because we see many patients in our office whose lives have been utterly ruined by an accident from which they should have long since recovered and resumed enjoying America.

I am very sorry that we cannot advance our date to come west so as to be able to see you personally and examine you and counsel with you. If Jim comes to Los Angeles to see us, perhaps he could bring the x-rays taken at the hospital where you were examined. I scarcely think it would be wise for you to come up horizontally in a station wagon just for my examination, since I have what seems to be the essential facts of your injury, and I am familiar with the problems involved. It is probably too good to hope that you will be so recovered as to be able to come up to Los Angeles under your own power.

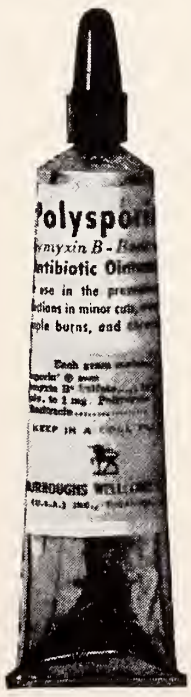
I trust all of this is understandable. I don't believe any of it is unnecessary advice. I would strongly urge you to follow it to the letter. I am asking my secretary to mail this and to send you an extra copy, since you might wish your orthopedist to see a copy, or possibly have your attorney photostat a copy for his record.

Again, I am sorry you are hurt, I am glad you did not mention the children as having been hurt and I am glad that what your injury appears to be is one from which you can recover fully.

With much love,
Dad

Gordon W. Batman, M.D.
1815 N. Capitol Ave.
Indianapolis, Ind.

in treating topical infections, no need to sensitize the patient



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Devoted to the interests of the medical profession of Indiana

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Josiah K. Lilly

JOSIAH K. LILLY, chairman of the Board of Directors of Eli Lilly and Company, died in Indianapolis May 5 at the age of 72. Mr. Lilly was the son of J. K. Lilly, Sr., and a grandson of Col. Eli Lilly, founder of the company.

He received a degree in pharmacy from the University of Michigan in 1914 and immediately began work, under his father as president. He successively served in practically every operation in the plant. He is credited with originating the Lilly personnel policy, and was instrumental in organizing its medical department for employees. He also established the sales research department and the efficiency division, and was intimately concerned with the Eli Lilly International Corporation and Eli Lilly Pan-American Corporation.

Mr. Lilly was famous for his philanthropies and for his modesty in relation to them. Indiana University built a library to house the rare book collection Mr. Lilly gave to it. Purdue University was the beneficiary of his gift of a huge stock farm and the Marine Historical Association received his collection of ship models and library on marine subjects.

He was also president of Lilly Endowment, the family foundation which grants substantial sums annually to religious, educational and community causes.

The New Look

THIS is the first issue of *The Journal* to take advantage of the modern and increasingly popular form of composition known as the three-column style. Despite the fact that there is a slight disadvantage from a production standpoint, in that our longer medical words do not fit as easily into short lines, there is a substantial improvement in ease of reading due to the shorter lines.

Facility of reading various styles of composition can be and has been measured by scientific means. Without having done such an experiment, however, it is obvious that a line of type may be so long as to make the return journey of the scanning eyes so time-consuming and inexact as to make it very difficult to pick up the succeeding line at its origin. Likewise, of course, lines of type may be so short as to be difficult.

Exact measurements of eye excursions, progression from line to line, fatigue of extra-ocular muscles and faltering of attention have determined that the ideal is close to that produced by the three-column setup. Stated in a non-scientific manner — eyeballs oscillate more easily up and down than they do sideways, and can "lock" into the next line with greater dispatch if they have not had such a long return from the far end of the previous line.

This issue is also set in a new type face. It is the same size as our old type face, but due to its intrinsic characteristics, appears to be blacker and more distinct. And despite the seeming greater distance between characters, more characters to the inch may actually be set than was the case with our former type face.

This type face is Bodoni. It was originally invented by the great Italian printer, Giambattista Bodoni of the 18th century. This is the modern counterpart, known as Bodoni book.

There is a rumor in some parts of southern Indiana that the Bodoni type face was named after Mr. George Graessle's horse — or it may be that it is the other way around. Anyway, we are indebted to the printers of *The Journal*, Graessle-Mercer, and to Mr. George Graessle and his staff for advice and much assistance in changing *The Journal* to the new look.

Hospital Practice

A new feature of *The Journal*, ap-

pearing for the first time in this issue, is devoted to a growing aspect of medical practice — that part of practice which occurs in or is oriented with the hospital.

Hospital news; clinicopathological conferences; postgraduate medical education activities in teaching hospitals; improvements in hospital utilization; extension of hospital facilities to outside patients; refresher courses conducted in hospitals for practitioners; cancer detection methods as elaborated in hospital practice — all these and many other facets of hospital practice will be reported each month in the new department of *The Journal* "Hospital Practice."

Approximately 20% of all physicians in the United States work full time in hospitals. In addition to this large group, the work of almost all practitioners is becoming more and more hospital-oriented. The attraction of great numbers of patients to the hospital emergency room, the gradually developing dominance of hospital staff societies over the traditional general medical society and the advent of many highly technical diagnostic and therapeutic procedures possibly only in, or at greater advantage in, the fantastically equipped modern hospital are all events and changes which remind us of the ascendancy and influence of hospital practice. All these factors are quite separate from the fact that today more patients are going to hospitals than ever before for serious illnesses and many more are hospitalized for childbirth and for minor illnesses which would have been cared for at home not too many years ago.

Health care is the third largest "industry" in the United States. Hospitals and hospital care are the fastest growing segments of total health care. Hospitals absorb an increasingly large proportion of the "health dollar" each year.

The events and developments which manifest and implement the vigorous growth of hospital practice will be reported in the new *Journal* feature — "Hospital Practice."

NJMS Celebrates Anniversary

THE Medical Society of New Jersey is celebrating the 200th anniversary of its founding. On July 23, 1766, 17 physicians met in New Brunswick and adopted "instruments of association" for "the advancement of their profession and promotion of the public good."

The Society, the oldest state medical organization in the United States, was vigorous from the start and has continued a long record of leadership in medicine and inspiration to its members.

Its vigor was tested early by the events of the Revolutionary War, many of which took place in New Jersey, and the gravity of which was sufficient to cause the young Society to meet in two sections in 1775. Half of its members served with General Washington and its fourth president, Dr. Nathaniel Scudder, was killed in action.

The members reassembled to resume professional pursuits in 1781, one month after the surrender at Yorktown. Their seal was adopted in 1786. In 1790 the bonds of the organization were strained by a rebellious member who persisted in operating an unapproved medical school. After 1807, however, the membership was reunited, and in 1816, district and county societies were authorized.

In 1819 its members took part in the first U. S. Pharmacopeia Convention. The state of New Jersey still honors tradition and the pioneer members of the medical profession by not rescinding a legal sanction (originally granted at about this time) which conferred upon the Society the right to award the M.D. degree.

The New Jersey Society was largely responsible for the establishment of the first state psychiatric hospital in Trenton in 1848. In the same year it participated in the founding of the American Medical Association and initiated publication of a quarterly medical journal, later published an *Annual Transactions*, which was succeeded in 1904 by the monthly *Journal of The Medical Society of New Jersey*.

Over 150 of the members served with the Union Army in the Civil War and returned from that conflict just in time to celebrate their first 100 years as a professional society.

The society is proud of its early sponsorship in 1932 of prepaid health insurance and hospitalization plans.

It is indeed fitting that the bicentennial celebration of the Medical Society of New Jersey should coincide with the 25th anniversary of Dr. Henry A. Davidson as editor of *The Journal of The Medical Society of New Jersey*. Dr. Davidson's tenure as editor has been as forward looking and as inspiring to his medical colleagues as has the 200 year history of the Society.

The title page of the original minute book of the Medical Society of New Jersey carries an inscription which influenced the Society at its inception and evidently has guided it through its glorious record:

> **They love therefore the fellowship of Science; and they thrive through Concord as well as common spirit.**

The Fourth District Medical Society Meeting

AS I attended the Fourth District Medical Society meeting at Madison on May 3, I could not help but observe that perhaps the program and atmosphere of this meeting really represented what is happening to medicine and what *will* happen to people in these challenging times.

In past years it has always been a joy to attend these meetings, to renew old acquaintances and to enjoy a little professional camaraderie. With the professional program geared to helping me help my patients (with excellent discussions of some professional aspect of the practice of medicine) I have always left the meeting feeling as though I was a better doctor for having attended and could better serve my patients by better understanding some aspect of their illnesses and health objectives.

This year's Fourth District meeting was devoted entirely to the ancillary aspects of the practice of medicine; the socio-economic aspects; the changing educational patterns; the government participation; the hospital's place. and the so-called public demands in the practice of medicine.

Nowhere could I detect a consideration of the illnesses or problems in my patient's best medical interests which might help me deal with their medical problems more effectively and thus make me a better doctor. I left the meeting a little rankled, feeling less enriched and more perplexed and apprehensive than anything else. It occurred to me that we are perhaps becoming overly concerned with the means and modes of delivery rather than the quality of the product. the real service to people.

I should like to remind the planners of the Great Society that diversion and defeat are likely to occur when admittedly high-sounding plans with admittedly worthwhile objectives are made wholly without any consideration of public awareness of the factors involved in the realization of these plans and objectives. The groundwork is laid for the complete and cruel frustration of the public and the doctors in creating expectations beyond public awareness.

It is difficult for me to understand how the planners on the one hand base the justification for their plans on the so-called poor health of the American people and on the so-called insufficient numbers of doctors and facilities — and on the other hand create and recommend an artificial system and law (PL 89 - 97) that will further dilute the doctor's efforts to educate and inform his patients on the medical and professional aspects of illness and health.

As the Fourth District Medical meeting was entirely consumed with the socio-economic aspects of medicine's future — I can envision my relationship with my patient being consumed by the socio-economic aspects of his illness rather than the medical. How am I to explain to him the deductible feature of his government insurance and the 80% feature of it and the difference between hospitalization and extended care; the difference between the nursing home that he now understands and the extended care facility; and just what is a spell of illness?

I am afraid if this is left up to me, I will have no time for his medical best interests. I find no provision in the law for relating the patient's unrealistic expectations of the law to its realities. If this is left up to me, I can only make an honest effort to do it — but I'm afraid the patient's medical best interests and explanations will have to suffer simply from my incapacities to assume both responsibilities honestly.

Being a physician trained and obligated to my patient's best medical interests. I suspect I will have to let the socio-economic aspects go unattended and will have to refer the patient to the agencies who created this problem for these explanations. I hope and pray I will not become less of a doctor because of the law.

These are the rankles I felt when I left the Fourth District meeting May 3rd, 1966. I would be more than relieved and pleased if H.E.W., Congressman Hamilton, Senator Bayh or Senator Hartke or someone, please, could give me some reassurance.—Robert P. Acher, M.D., Greensburg.

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Editorial Notes . . .

At one time, obstetrical care started when the labor pains started. Health education, higher income levels and the greater accessibility of doctors has greatly improved prenatal care. The Health Information Foundation reports that while 10 years ago only about a third of pregnant women consulted a physician as early as the second month, now over one-half do. Whereas only two-thirds of the prenatal patients were seen in the third month in 1953, now over three-fourths are seen. Frequency of prenatal visits has increased steadily until now 61% of the patients are seen at least ten times prior to delivery.

Many patients with chronic myelogenous leukemia (CML) have a chromosomal abnormality identified as the Philadelphia chromosome. With few exceptions, this chromosome is only found in persons with CML. There are interesting clinical differences between CML patients who have the abnormal chromosome and those who do not. The negative group respond less well to treatment, die sooner, have lower white blood cell and platelet counts and include a larger proportion of females and children under seven. The two types of CML may be different entities. ◄

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Precautions: Reduce dosage of concomitant antihypertensive agents by one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take particular care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use with caution in patients with ulcerative colitis, gallstones, or bronchial asthma.
Side effects: Nausea, vomiting, diarrhea, muscle cramps, headaches and dizziness. Potential side effects include angina pectoris, anxiety, depression, drowsiness, hyperglycemia, hyperuricemia, lassitude, leukopenia, nasal stuffiness, nightmare, purpura, urticaria, and weakness.
For full details, see the complete prescribing information.
Availability: Bottles of 100 and 1000 tablets.

Geigy

President's Page

At the end of June, just a few days before the 1st of July and the beginning of Medicare, we still have not received many of the important regulations dealing with Medicare. I have stated before, much of this appears to be a deliberate delay on the part of the Governmental agencies who are writing the regulations — *and not* necessarily in conformity with the intent of the law.

By the time this *Journal* reaches your desk, I am sure many of these problems will be apparent to you. I would assume that many of the decisions will be troublesome, irresponsible and will create all types of problems for you. I have repeatedly stated that I believe many of these regulations will be so prepared that they will be unworkable, untenable and will place a great strain on the physician-patient relationship — by intent.

I have attempted to delineate these areas of concern. The ISMA Council, by policy, statements and resolutions, has done likewise.

Today many of us have attended an AMA seminar on Medicare preceding the annual AMA meeting. We have learned nothing from Government sources to reassure us. I feel that confusion, delay and deception await us.

What can we do?

In my opinion, only a concentrated effort from this moment forth by all physicians to change the complexion of Congress, in the November 1966 election, can help us. Our only hope is that each of you will devote your time and your money from now until November in an attempt to change or to neutralize this growing menace. Reasonableness, cooperation or delay can only drive us further down into the subservient position that has been prepared for us.

In the meantime, let us redouble our efforts to provide quality medical care for all, irrespective of regulations. Let us give whole-hearted support to those specialists who are now most affected by government regulations because all of us are due for the same treatment if we cannot make a change.

K. D. Neumann M.D.

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Precautions: Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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REPORTS TO ISMA

It was recently my privilege, along with Dr. and Mrs. Neumann and representatives from the medical societies of several other states, to be the guest of the Wisconsin Medical Society and its auxiliary at their annual convention held in LaCross. Despite the unseasonable coolness of the weather, there was a warmth and friendliness that pervaded every session.

One of the highlights of the program was the History Seminar Beaumont Dinner held on opening night. I had recently stood beneath the large portrait of Dr. William Beaumont which hangs in a corridor of Barnes Hospital in St. Louis. There he located near 1840 and was elected president of the Medical Society of St. Louis. He was instrumental in the appointment of the first board of health, which, by finally putting on a quarantine, succeeded in stopping the cholera epidemic of 1848, which was causing 600 deaths per week in the city of 36,000. His funeral in 1853 was attended by throngs of his patients.

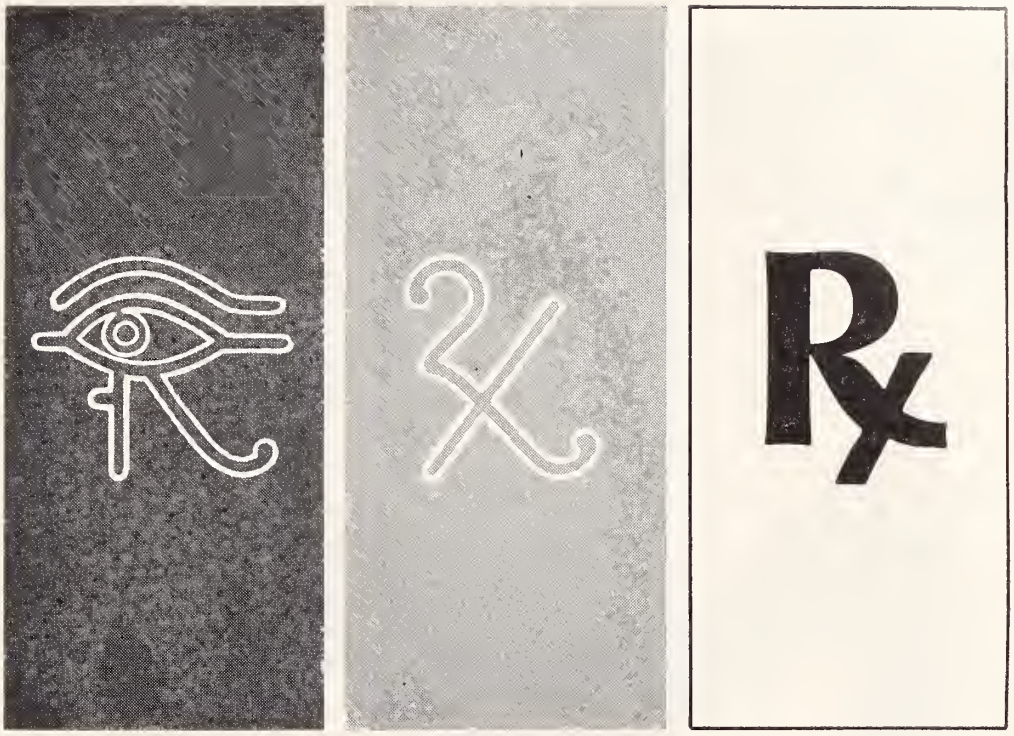
His early life was spent far from St. Louis. Born in Connecticut in 1785, educated in the University of Pennsylvania and Columbia University, Dr. Beaumont early joined the Army and was stationed for some time at Fort Mackinac, Michigan. There in 1822 he cared for Alexis St. Martin, an 18-year-old Canadian voyageur for the American Fur Company. St. Martin had been accidentally shot from a distance of about a yard. He received the whole charge of the musket in his left side; it carried with it portions of his clothing, fractured two ribs, lacerated the lungs and entered the stomach.

I was fascinated by the reports on his treatment, which included a mixture of ammonia and vinegar and camphor given internally. In a year St. Martin was enjoying good health and doing light work, with an aperture opening into his stomach about two and one-half inches in circumference.

Meanwhile Dr. Beaumont had moved to Prairie du Chien, a few miles from LaCrosse, where the military hospital of the War of 1812 is preserved as a museum. There he continued a series of experiments on the stomach of St. Martin, showing its operations, secretions and the action of the gastric juices. Beaumont published a report of his work, "Experiments and Observations on the Gastric Juice and the Physiology of Digestion" in 1833. Although the opening in his stomach never closed, St. Martin lived to the age of 86.

This was a very special session for the Medical Society of Wisconsin — it was its 125th anniversary meeting. The society was organized four years before Wisconsin became a state.

Mazo D. Scales



AWARENESS

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Convenience: Lomotil is supplied as small, easily carried, easily swallowed tablets and as a pleasant, fruit-flavored liquid.

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- **Ulcerative colitis**
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- **Functional hypermotility**
- **Malabsorption syndrome**
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Dosage: For full therapeutic effect—Rx full therapeutic dosage. The recommended initial daily dosages, given in divided doses, until diarrhea is controlled, are:

Children: 3 to 6 months — 3 mg. (½ tsp.* t.i.d.)
6 to 12 months — 4 mg. (½ tsp. q.i.d.)
1 to 2 years — 5 mg. (½ tsp. 5 times daily)
2 to 5 years — 6 mg. (1 tsp. t.i.d.)
5 to 8 years — 8 mg. (1 tsp. q.i.d.)
8 to 12 years —10 mg. (1 tsp. 5 times daily)

Adults: 20 mg. (2 tsp. 5 times daily or 2 tablets 4 times daily)
*Based on 4 cc. per teaspoonful.

Maintenance dosage may be as low as one-fourth the therapeutic dose.

Precautions: Lomotil, brand of diphenoxylate hydrochloride with atropine sulfate, is a Federally exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates. The subtherapeutic amount of atropine is added to discourage deliberate overdosage.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness, insomnia, numbness of extremities, headache, blurring of vision, swelling of the gums, euphoria, depression and general malaise.

SEARLE *Research in the Service of Medicine*

Hospital Practice

Cardiopulmonary Resuscitation

CARDIORESPIRATORY resuscitation is greatly facilitated by a newly-devised mobile vehicle which contains all the commonly used resuscitation and intensive care instruments and supplies and in addition affords a stretcher top upon which the patient may be placed for prompt treatment.

During resuscitation, the patient may be transported to the operating room or to the x-ray department without interrupting the intensive treatment. The vehicle may be used as an operating table in surgery, and as an intensive care bed immediately after operation.

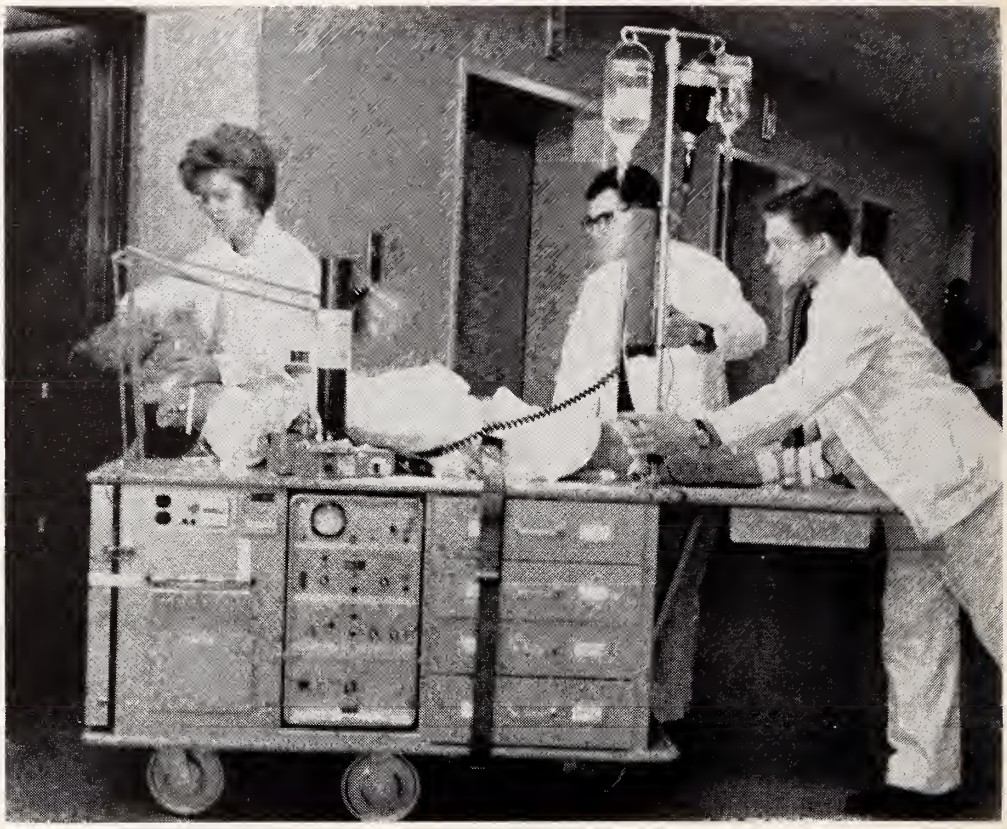
The novel device was designed by Dr. Joel Nobel, a resident in surgery in Pennsylvania Hospital, Philadelphia, and has been used over 60 times in that hospital. It was built by a subsidiary of Smith Kline & French Laboratories, Corbin-Farnsworth of Palo Alto.

By way of comparison, a conventional emergency cart takes some six to eight persons over three minutes to set up, while with the new system, three or four persons require only 26 seconds to accomplish the same task.

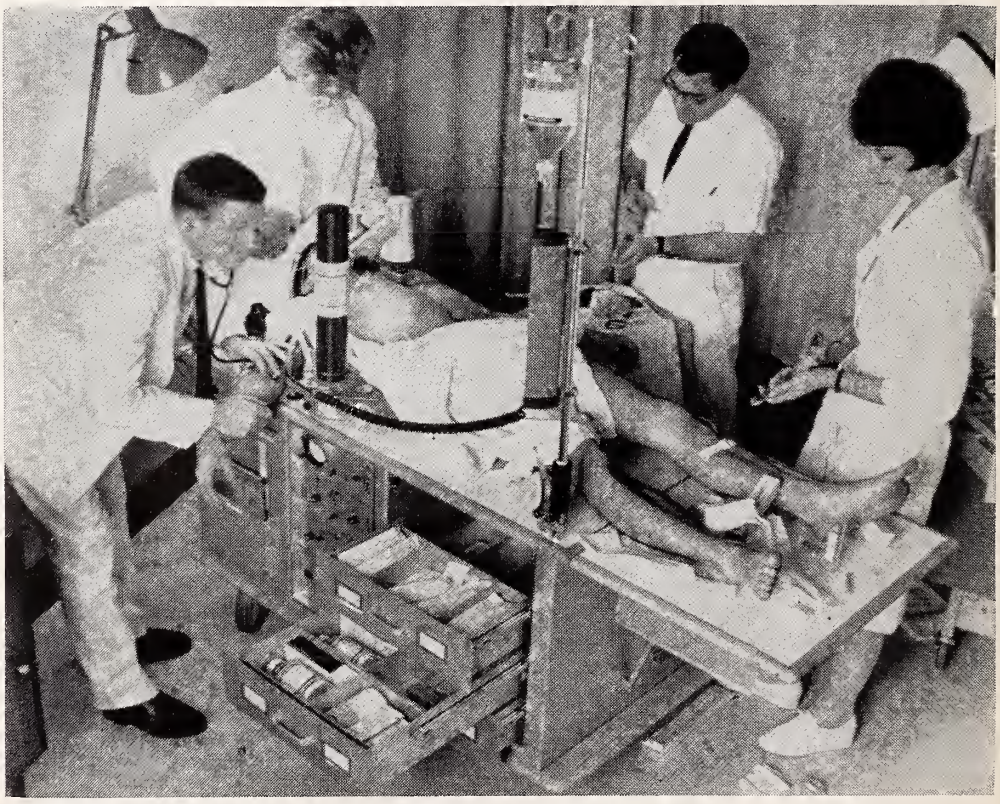
In a small hospital not equipped with an intensive care unit, the cart may be used as a mobile intensive care facility.

A respirator, a pneumatically-powered external cardiac compressor and an electrocardiograph are all a part of the cart and may be activated as soon as the patient is placed on the top surface. Supplies for surgical cutdown for infusions and transfusions, endotracheal intubation and all emergency drugs are contained within the drawers and compartments. An oxygen supply and self-contained electric power source enable the smooth functioning of the complex while it and the patient are being moved.

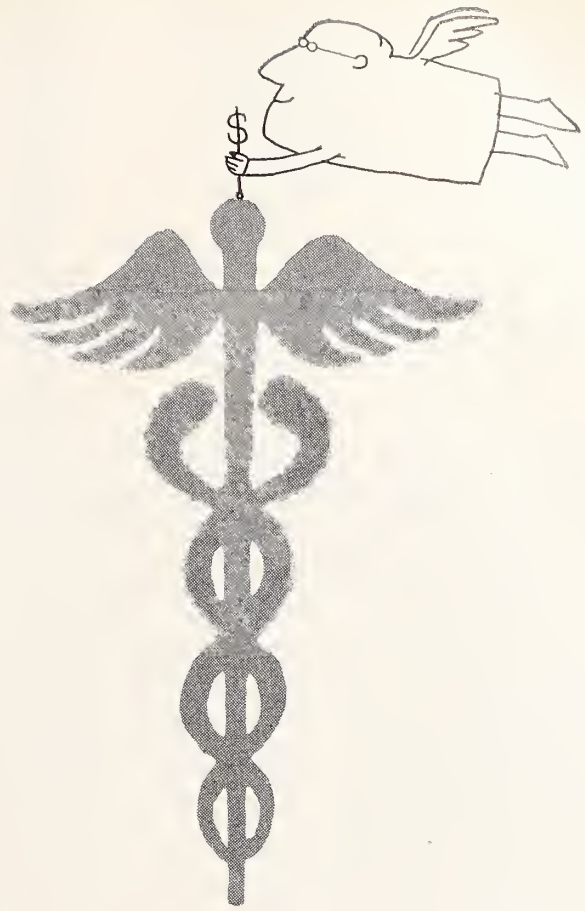
An automatic data acquisition system records doctors' orders, activities of attendants and all physiologic data. ◄



WHILE receiving emergency treatment for cardiac arrest, patient is shown in a simulated scene being wheeled on life support system, nicknamed MAX, into elevator for continuation of treatment elsewhere.



SPECIALLY-TRAINED emergency cardiopulmonary resuscitation team at site of cardiac arrest at Pennsylvania Hospital, Philadelphia. The simulated scene shows the patient just after he has been lifted onto mobile life support system nicknamed MAX.



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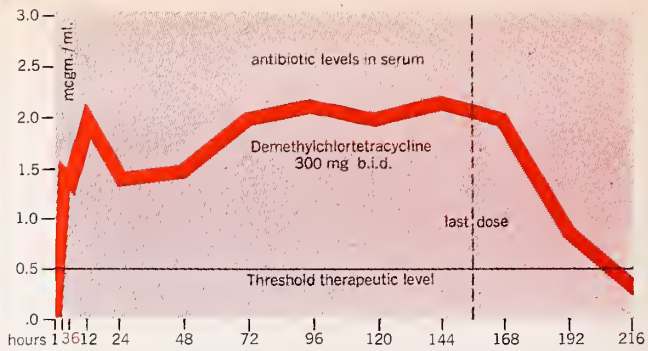
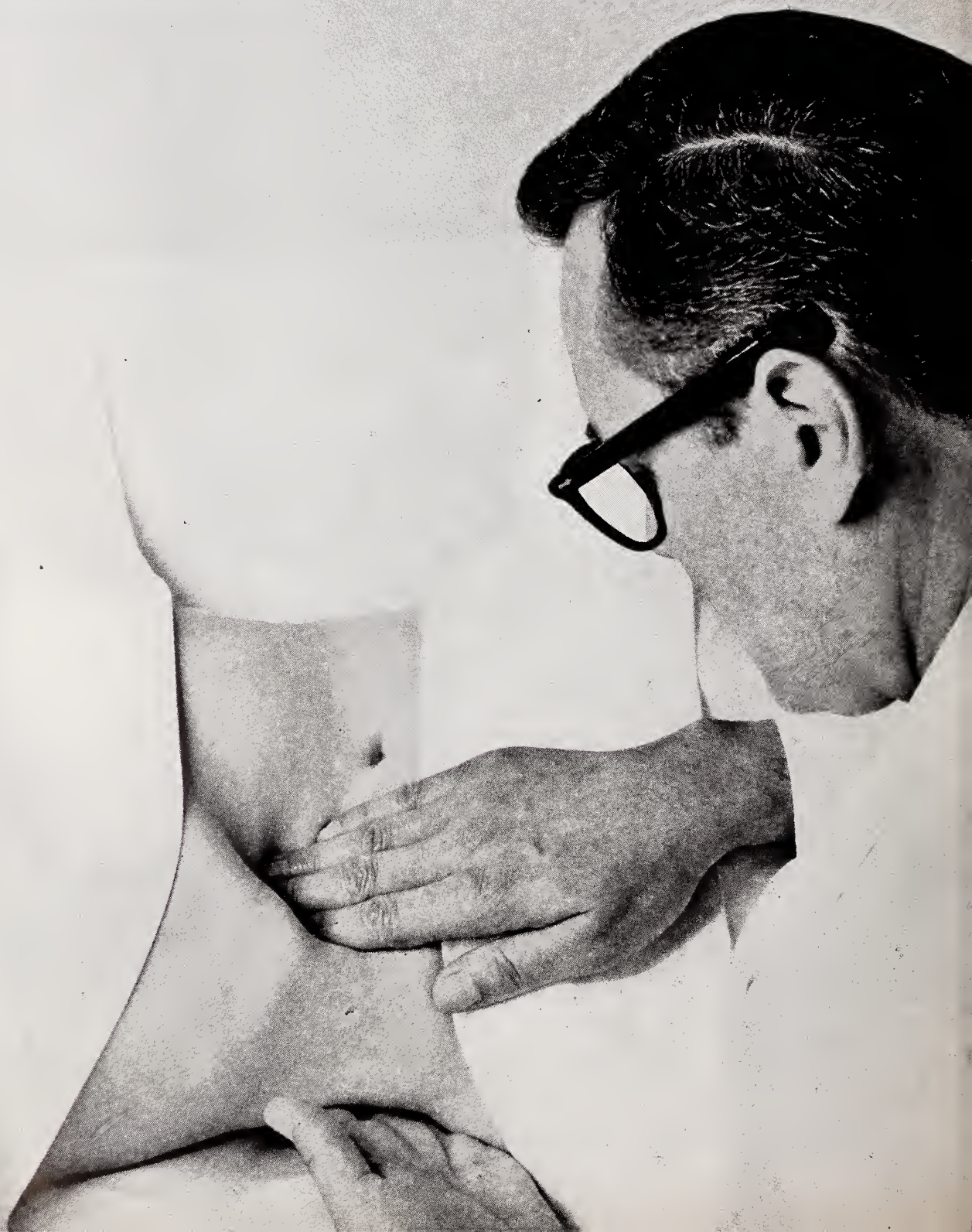
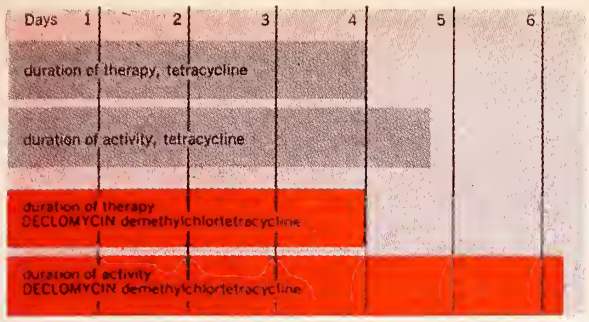


higher activity

levels than ordinary tetracyclines

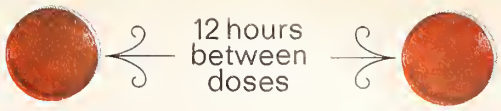
From Sweeney, W. M.; Dornbush, A. C., and Hardy, S. M.; Amer. J. Med. Sci. 243:296 (Mar.) 1962





1-2 days' "extra" activity

after the last dose to protect against relapse



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Precautions and Side Effects—Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. Use of demethylchlortetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect occurs mostly during long-term use but has also been observed in short treatment courses. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment. Side reactions include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and dermatitis. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Anaphylactoid reactions have been reported.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products.

Capsules: 150 mg; *Tablets:* film coated, 300 mg, 150 mg, and 75 mg of demethylchlortetracycline HCl.

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Medicine in a Rapidly Changing World*

KENNETH E. PENROD
Indianapolis†

TWO REASONS underlie the choice of my topic. First, I am afraid that you may have been so occupied recently with the day-to-day tasks of medical school that some of the highly significant social forces of our day — forces destined to have a profound influence upon your professional career—may have escaped your notice. Secondly, each year as graduation time approaches, I get the uneasy feeling that we as medical educators are so obsessed with the "nuts and bolts" of medicine that we forget it is our role to help you become good citizens first and good physicians second. Maybe what I am about to say will give you a bit more breadth in your preparation for what is to come.

In order to focus more clearly on where we are today and how we got here, I would like to take you back a bit into history. Medicine has a long and illustrious past, but I would like to go back only about 65 years, to the turn of this century.

In the early 1900's medicine was largely learned by following and observing an older practitioner as he went about his daily routines. For that period this method was probably entirely appropriate for the total fund of knowledge to be learned — the scientific basis of medicine — was quite thin. It was, however, about this time that the sciences applicable to medicine underwent a rapid development. Chemistry, physics, biology and the subdivisions of anatomy and physiology were flourishing in some of the universities. A few medical schools were beginning to incorporate this growing knowledge into their preparation for the practice of medicine.

Time Right for Changes

About this time a strait-laced young non-medical educator made a thoroughgoing nationwide evaluation of medical education and training and produced a report for the Carnegie Foundation for the Advancement of Teaching in which he pointed out the dreadful conditions then extant. We're all acquainted with the impact of Mr. Flexner's report and how many of the so-called "schools" of that day were nothing more than diploma mills run solely for the financial benefit of the proprietor.

The point not to be lost sight of is that had Abraham Flexner not made his study and report in 1910, it is quite likely someone else soon would have. The *time* and the *setting* were ripe for sweeping change. The newly developing sciences basic to medicine *had* to be incorporated, but not everyone saw that clearly until it was rather forcefully pointed out.

Unlike most reform advocates, Mr. Flexner was then handed the tools with which to see to it that his recommended reforms were carried out. These tools were in the form of substantial sums of foundation money that no educational institution could afford to ignore, respectable or not.

For the next 30 years, to the time of World War II, medical education became progressively deeper rooted in its scientific and academic soil and medical care was the better for it. In this time, incidentally, all of the schools that could not attain accreditation status folded and as a result the number shrank from of the order of 160 to about 60.

World War II had a marked effect on Americans in many ways and seemingly one of them was to give us supreme confidence that if a sufficient concentration of brains and money could be brought to bear on a given problem, that problem would yield, as did that of the atomic bomb. So in this mood, further stimulated by a desire to live longer, better lives, an era of unprecedented concentration upon medical research began in the late 1940's.

We have since been through nearly 20 years of constantly expanding medical research. Support for this effort has been generously increased each year from a number of sources but principally the National Institutes of Health. The efforts and talents of the medical school faculty have been increasingly devoted to the discovery of new information. Others, too, have contributed enormously to a mounting pile of medical knowledge. Meanwhile, the public has been fed large doses of insight into these achievements and has savored the great breakthroughs such as the conquest of poliomyelitis. It has been made fully aware of the extent of the effort, the amount spent, the fact that as many as 59 research workers from the Indiana University School of Medicine recently presented 22 papers on medical research topics at a single meeting — yet that same public is asking why its backache still persists and why its physician can really do little or no more for that nasty head cold than he could 25 years ago.

A Disenchanted Public

There are unmistakable signs of a rising public disenchantment with the direct benefits of this enormous research effort. For many reasons — some real and some imagined — there is restlessness over the uneven distribution of available medical care. This discontent was reflected clearly about

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* Adapted from the Annual Alpha Omega Alpha Lecture, Indiana University School of Medicine, April 27, 1966.

† Provost, Indiana University Medical Center, Indianapolis.

two years ago with the appointment of a Presidential Advisory Committee charged with suggesting ways and means for narrowing the time lag between what is found in the research laboratory and what is available in the way of everyday health care. The report of this committee formed the basis for last fall's Public Law 89-239, popularly known as the "Stroke, Cancer and Heart Disease" bill, which may well turn out to be one of the most significant pieces of legislation passed by the Congress in many years, at least so far as health is concerned.

In the early 1900's, the sweeping change in medical education (which, of course, later reflected in medical practice) was directed to a forced marriage of medicine with the fundamental sciences. With this came academic respectability and a half century of enormous advances in medical knowledge. Are we now on the threshold of a new era, perhaps ultimately to prove to be as important as the so-called Flexner Era — one in which the emphasis is to be on better ways and means for delivering health care?

By no stretch of the imagination do I mean to imply there will be a lessening of the dependence of medicine on fundamental science. Nor do I expect that there will be any actual reduction in the support of laboratory research. But I do expect — in fact the evidence is clear — there will not be in the near-term future anything like the *expansion* of laboratory research we have witnessed over the recent past. The attention of the public as reflected in their elected representatives has now turned from support for research into the sociology of medical care. Medical education and medical practice are going to find themselves in a much closer working relationship than has been true for a long time.

This new partnership, I dare say, will be overwhelmingly to the benefit of both. Both, after all, are really interested in achieving the same goals and each has something to offer the other that is of great potential value. But the relationship is likely to cause a few stresses and strains as the new cooperative ventures work themselves out.

Now I would like to turn for a few minutes to a new, but not totally unrelated, subject which is also destined to have marked effect on your professional lives. I'm speaking now of the fascinating new world of data storage, retrieval and dissemination.

I'm sure you don't need to be told about information overload. You have been spending much of your lives to now acquiring new facts — perhaps more facts than you can find immediate application for. Unfortunately, your storehouse of information is in dynamic equilibrium and will be constantly in need of replenishment. Many of the "facts" of today won't be "facts" tomorrow. But be of good cheer — aid is coming!

Until now our civilization has depended upon the human memory and the printed page for the storage and retrieval of information. Now newer, faster and better techniques are here to supplement and even to some extent make obsolete these older methods of preserving data.

Let me cite for you just a few of the newer developments and their experimental application that are with us today. In so doing, I can only provide a foundation for visualization of what these techniques may be expected to lead to in the very near future.

Computerized Knowledge

Highly sophisticated large new computers now exist, such as the IBM 360-67 or GE 645, which are capable of operating a hundred or more remote terminals in an on-line, time-sharing system. Such instruments are capable of handling an incredible number of bits of information, each bit being almost instantaneously available to any of the locations. Each of the terminals may have a voice connection plus an electronic typewriter and a modified television screen or cathode ray tube on which the computer can display such things as pages of books and serials requested by the typewriter, or carry out many kinds of programmed instruction. The connections may be by wire or microwave transmission. It is possible for a person at one of the remote terminals to signal the computer by shining a light pencil on the face of the television screen. With this, he can point to a part of the display on the tube, such as a correct answer, or he may by this means signal further information desired. The information placed on the light screen or in the typewriter can be stored in the computer memory and become a part of the system if it is desired.

Telefacsimile machines are in the early stages of development which are capable of receiving signals from computers over long distance telephone lines and translating them into printed pages at a rate of about a page a second and at a cost of a cent or two per page. This equipment can also reproduce pictures and diagrams clearly. Photoreaders are now on the market which can read typed material directly into the electronic storage, and it is reasonable to expect that within two or three years, printed material can be automatically transferred to electronic storage at very high rates of speed.

Programs are now being written and constantly improved which will make it possible for computers to abstract and index electronically stored documents; to translate information from one language to another; to notify users automatically of new information which fits into their field of interest; to "read" electronically stored documents and print out paragraphs or sentences in response to questions posed; and even to browse through documents over long distance telephone lines.

Such a local network of communication technology can be viewed as ultimately a part of a nationwide network connecting to, among other places, both the Library of Congress and the National Library of Medicine. It is wholly within reason to anticipate that all of the material of the National Library of Medicine can be available in

remote communities as readily as in the major teaching centers. Areas of medical isolation should be completely obliterated in the foreseeable future.

How It Works

All of the technologies discussed above are in some form of production at the moment. Unfortunately, the cost is still quite high but this will be resolved in a short time. Meanwhile, a number of places in the U. S. are conducting important experimentation in various uses of these technologies. For instance, the Massachusetts General Hospital has been for some time carrying out experiments such as:

1. The mechanics of patient admission can be greatly speeded up by automation. The computer has in its memory an instantly available record of each room and every bed in the hospital. This includes type of room, price, and whether or not filled. The answers to a few questions put to the patient can result in almost instantaneous bed assignment.

2. The results of clinical laboratory tests can be fed directly into the computer and made available at a location near the patient. Further requests can be typed on a nearby electric typewriter and immediately recorded in the clinical lab. The computer can be programmed to format the laboratory data in a variety of ways including instantaneous recall in a series of sequential tests.

3. Drugs can be prescribed by this computer system. A physician may request pharmacologic information about any drug. If he misspells the name of the compound, the computer will suggest to him the correct spelling. The computer will also tell him the route for administration of the drug, the maximum single dose, the maximum daily dose, alternate proprietary names for the drug, and similar information. If he orders an improper dosage, the computer will immediately warn him and inform the pharmacy. On request, the computer can print out an updated list of all current medications for a given patient or tell the nurse all the drugs she is expected to administer to patients on her ward at a given time.

4. This system can also search through hospital records for medical research purposes and can format the data. It can locate a given number of records showing any specific diagnostic condition, symptom, or sign, and then can analyze these data according to age, sex, duration of medication, clinical findings or any other variable which interests the clinical scientist.

Updating the Data

It is obvious that the techniques being demonstrated at the Massachusetts General Hospital herald the entrance of a new world of medicine. It requires no stretch of the imagination to visualize an instantly available memory library of pertinent facts such as latest information on emergency treatment procedures, poisons, burn therapy, antibiotics and side effects, and many other bits of information the practicing physician needs at his fingertips. A complete bibliography on any subject can be made available through the use of the National Library of Medicine's MEDLARS tapes. Computers may someday even become smart enough to suggest how to cope with the many different insurance forms! It is also conceivable that terminals will be readily available in the community hospital, in the clinic and even in the individual practitioner's office. Consultation and aid will be immediately available to every practitioner at all times. A local network can have a vast storehouse of "canned" data electronically stored. (Of course this presupposes that someone must be responsible for constantly updating the stored data.)

While discussing the seemingly limitless possibilities of the computer technology in their application to the practice of medicine in the future, we should not ignore the as yet largely unrealized potentialities of closed circuit television. This technique, too, has much to offer, especially for consultations, teaching sessions, clinics, etc. The surface has barely been scratched in these technologies which, like those of the computer, are going to be with us soon. Let me repeat, these are not pipe dreams.

From a medical standpoint we are greatly favored in Indiana. We have four state-supported universities with our Medical School and teaching Medical Center located almost at the geocenter. Plans are well advanced to complete the electronic hookup of these five institutions. In addition, regional campuses now exist in all of the higher population densities of the state and plans are taking shape for an extension of the campus link-up to include all of these regions which in effect means a statewide electronic network. Once this framework is established it will be a relatively simple next step to tie in a complete medical communications complex. In such a system, all areas of the state can have equal access to the same material — library, live and "canned" instructional programs, electronically stored factual data, consultation, and easier patient referral and follow-up. The entire state will indeed become a medical unit where there need not be any places of medical isolation.

So, in conclusion — and I suspect that some of you thought we would never get to this point — I am reminded of a recent speech by Chancellor Heard of Vanderbilt University in which he quoted the following "Lines Composed in Fifth Row Center":

Of all the kinds of lecturer
The lecturer I most detest
Is he who finishes a page
And places it behind the rest.

I much prefer the lecturer
Who takes the pages as he finishes
And puts them on a mounting pile
As the original pile diminishes.

But best of all the lecturer
Who gets his papers in confusion
And prematurely lets escape
The triumphant phrase, "And, in conclusion. . . ."

What I have been trying to say to you is that the world of medicine of which you will be a part for perhaps the next 40 years will be a quite different place than we have seen up to now. Many of us have been attempting for some time to assess the factors shaping this future in order to plan for a rational and meaningful medical education geared to the future in our state and nation, not the past.

You are very fortunate to be entering the field of medicine at this time. It is going to be an exciting period while continuing to yield untold satisfactions to those who can qualify for this profession. You here tonight are doubly fortunate in being so well endowed with the abilities called for in the practice of medicine, as your election to AOA has so clearly underscored. May you prove worthy to serve the suffering. ◀

Principles of Reimbursement for Hospitals and Other Institutions Providing Services to Medicare Beneficiaries

Statement by Robert M. Ball
Commissioner of Social Security
May 2, 1966

THE principles we are issuing today will provide payment for high quality care for our older citizens. They will result in a significant increase in the income of almost all hospitals and other institutional providers of service since today hospitals frequently do not get full reimbursement for the care which they furnish older people.

The national principles of reimbursement will be applied locally on behalf of the program by Blue Cross and certain private insurance companies acting as fiscal intermediaries. These voluntary insurance organizations were selected after nomination by groups or associations of hospitals. Extended care facilities and home health agencies may similarly nominate such intermediaries. The fiscal intermediaries will be responsible for paying the bills of program beneficiaries for covered services received in participating hospitals and other institutions under the Medicare program.

The purpose of the principles of reimbursement, as stated in the law, is to enable the intermediaries to determine the "reasonable cost" of institutional services provided Medicare beneficiaries.

In the development of the principles of reimbursement there has been extensive consultation with representatives of the American Hospital Association and with many others including representatives of the American Nursing Home Association, the American Association of Hospital Accountants, the National Blue Cross Association, individual Blue Cross plans and state and federal agencies which purchase hospital and institutional services.

There have been meetings also with hospital directors and comptrollers, nationally recognized authorities in the field of health care costs and many other interested individuals and organizations.

The Health Insurance Benefits Advisory Council, a 16-member non-federal group has given prolonged attention to the problems of cost reimbursement under Medicare and the principles announced today are based on their advice and have their support.

Lack of Solidarity

It was to be expected that there would be differences of opinion over some points in the principles. Not only do consumers, providers and other groups look at issues from somewhat different viewpoints, but this is a large country with very diverse conditions, and what seems reasonable for a large part of the country may create special problems in individual localities. For example, several groups urged us to pay on an average per diem basis for all patients which would have increased the overall cost of the program by nearly 10%. Available information shows average daily costs for aged patients are less than average daily costs for younger patients. Therefore, it would not be proper to reimburse hospitals on this basis for aged Medicare beneficiaries. In spite of a lack of unanimity on some points, we have, I believe, adopted fair and ac-

ceptable principles arrived at by a process of full consultation among reasonable people.

These principles are realistic and they are flexible. It is recognized they will have to be tested and their impact studied. After the first full year of operation under these principles, we will evaluate their effect and move quickly to make any changes which seem called for.

In developing the principles of reimbursement, we and the others who have participated were mindful of certain weaknesses that have existed in some other third-party reimbursement arrangements in the past. We were mindful, too, of new goals in providing reimbursement, and we were mindful of the statutory requirements and the legislative history of the Medicare program. Putting these several points together, we evolved certain tests for the principles of reimbursement and certain goals they should be designed to accomplish.

In general terms, these are the tests or objectives:

1. That the methods of reimbursement should result in current payment so that institutions will not be disadvantaged, as they sometimes are under other arrangements, by having to put up money for the purchase of goods and services well before they receive reimbursement.

2. That, in addition to current payment, there should be retroactive adjustment so that increases in costs of other factors are taken fully into account as they actually occurred, not just prospectively.

3. That there be a division of the allowable costs between the beneficiaries of this program and the other patients of the hospital that takes account of the actual use of services by the beneficiaries of this program and that is fair to each hospital individually.

4. That there be sufficient flexibility in the methods of reimbursement to be used, particularly at the beginning of the program, to take account of the great differences in the present state of the art of recordkeeping.

5. That the principles should result in the equitable treatment of both nonprofit organizations and profit-making organizations.

6. That there should be a recognition of the need of hospitals and the institutional providers to grow and to improve.

Full Coverage?

The law and the reports of the Committee on Ways and Means and the Senate Finance Committee direct us to pay the reasonable cost, in full, of care furnished beneficiaries so that as a result of this program, no part of their cost would need to be borne by other patients of the hospital. Conversely we are not to pay for any costs attributable to other patients of an institution. The Committee Reports gave considerable guidance on the specifics of reimbursement, but also directed us to consider the principles of payment now in use by various national organizations.

The application of these principles, with appropriate accounting support by each hospital or other institutional provider will result in meeting actual costs, as they vary from institution to institution. All necessary and proper expenses, including normal standby costs, are recognized. For example, over and above the direct costs for room, dietary, nursing service and ancillary services, the principles will take account of such factors as depreciation and necessary and proper interest on both current and capital indebtedness. The problem of determining costs under Medicare has two parts — what are allowable costs and, then, how does one allocate the share of the allowable costs that are related to the services furnished the beneficiaries of this program? In addition, there is a third area of policies and procedures related to the flow of payments.

Under the question of allowable costs some items of inclusion and exclusion are:

— An appropriate part of the net cost of approved educational activities will be included.

— Costs incurred for research purposes, over and above usual patient care, may not be included.

— Grants, gifts, and income from endowments will not be deducted from operating costs unless they are designated by the donor for the payment of specific operating costs.

— The value of voluntary services provided by sisters or other members of religious orders is includable in the amount that would be paid other employees for similar work.

— Discounts and allowances received on the purchase of goods or services are reductions of the cost to which they relate.

— Bad debts may be reimbursed (after bona-fide efforts at collection) growing out of the failure of a beneficiary to pay the deductible or the co-insurance applicable to stays between 60 and 90 days.

— General charity and courtesy allowances are not includable, although "fringe benefit" allowances for employees under a formal plan will be includable as part of their compensation.

— A reasonable allowance of compensation for the services of owners in profit-making organizations will be allowed providing their services are actually performed in a necessary function.

— Depreciation. Depreciation will essentially be on a historical basis and since many institutions do not have adequate records on old assets, the principles provide an optional standard allowance in lieu of such depreciation for assets acquired before 1966. For assets acquired after 1965, the historical basis must be used. All assets actually in use for production of services for Medicare beneficiaries will be recognized, even though they may have been fully or partially depreciated for

other purposes. Assets financed with public funds may be depreciated. In general, the options for accelerated depreciation allowed by the income tax laws will be permitted. Although funding of depreciation is not required, there is an incentive for it since in computing the allowable interest expense that an institution may include as a program cost, income from funded depreciation is not considered as an offset which must be taken to reduce interest expense.

We are also including an allowance in recognition of the continuing need for capital funds to secure, preserve and improve service rendering capability. In part this allowance is in lieu of a direct return on net capital investment and in part is a recognition of various uncertainties that are inherent in the application of any cost formula at this stage of our cost-finding capability. The allowance will apply to both non-profit and profit-making organizations alike. Thus we will avoid the anomalous result that would arise from reimbursing a profit-making organization more than a non-profit organization for rendering exactly the same service solely by reason of allowing a return on investment in one case but not the other. The allowance will be computed by taking two percent of total allowable cost (for purposes of determining this base interest expense will be subtracted). The amount computed will be subject to the limitation that the total allowance not exceed a reasonable long-term interest rate on net capital investment.

Two Methods

In determining what proportion of allowable costs are attributable to Medicare beneficiaries as distinct from other patients, two alternative methods are provided:

1. *Departmental Method* — The ratio of beneficiary charges to total patient charges for the services of each department is applied to the cost of the department.
2. *Combination Method* — The cost of "routine services" (room, dietary and nursing services) for program beneficiaries is determined on the basis of average cost per diem of these services for all patients; to this is added the cost of ancillary services used by beneficiaries, apportioned on the basis of the ratio of beneficiary charges for ancillary services to total patient charges for ancillary services. For the first 18 months of operation, the division of total hospital cost (between "routine" and ancillary) required by the combination method may be done on the basis of estimates.

Payments will be made as often as possible and in no event less frequently than once a month. Final settlement will be made retroactively at the end of the accounting period. The retroactive payments will take into account costs as they were actually incurred and will settle on an incurred, rather than on an estimated, basis.

Further, hospitals will be provided interest-free advances of funds so that they will not have to lay out money for goods and services provided to Medicare beneficiaries and lose the interest that money might otherwise draw. A month's payments — amounting nationally to an anticipated $200 million — may be advanced to hospitals to cover services provided in July when the Medicare program goes into effect.

The advance will be a continuing one and will be based on the estimate developed by the hospital, related to the Medicare's program's share of one-twelfth of annual operating expenses. ◀

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Gleaned from the British Medical Journal

JACK W. HICKMAN, M.D.
Indianapolis

Gradual Withdrawal of Anticoagulants

Physicians have always cautioned against abrupt withdrawal of anticoagulant therapy because of the fear of "rebound" hypercoagulability that might result. During this phase it has been feared that new thrombotic episodes would occur. There has been clinical, laboratory and statistical evidence to support this position. A study by Poller and Thomson[1] reports their results of gradual withdrawal of anticoagulant therapy over a four-week period of time. The ten patients reported had been on anticoagulants for an average of 14 months. No hypercoagulable state was observed by laboratory determinations. The relative leveling-off of the coagulation measurements at about three weeks, however, suggests to the authors that patients should be gradually tapered off anticoagulant therapy over an even longer period of time.

Gastric Carcinoma

Brookes et al. report on a 10-year-survey of 5,441 cases of carcinoma of the stomach who were documented at a major referral center in England.[2] The dismal picture of this malady is reflected in their report, and their five year survival rates were just about the same as the five percent rate for all cases reported from a number of centers in this country. In only 25% of all cases was radical "curative" surgery possible, and of these cases, there was an 18% five year survival. Another discouraging fact was that there was no seeming improvement in prognosis of the newer patients over those treated in 1950. The location of the tumor had little effect on survival, but those located near the pylorus had a slightly better prognosis. The only major factor influencing prognosis was duration of symptoms; and, as one would expect, those with the shorter duration of symptoms had the most favorable prognosis as to operability and, therefore, survival. This is a well-written and quite sobering report.

Thoracic Sympathectomy for Angina Pectoris

Birkett et al. have resurrected a bilateral upper thoracic sympathectomy as therapy for angina pectoris and report on their results in 52 cases.[3] Procedures of this sort have been around for roughly half a century, but are brought back and/or modified every few years. Since this work was done at St. Bartholomew's Hospital by capable men, however, it should be noted with some interest. The authors state that 28 patients became free from pain or had greatly increased effort tolerance, and 14 had some improvement. They believe that the procedure did not merely mask pain, but actually improved myocardial performance; and they believe that it should be considered for patients with stable severe angina who are refractory to medical treatment. Nonetheless, it must be recorded that four patients died during surgery, 10 had major postoperative complications (myocardial infarction, pulmonary infarction, hemiplegia, etc.), and 19 had "minor" postoperative complications (pleural effusion, atelectasis, phrenic nerve damage, etc.). All-in-all, it may take another half century to settle this issue.

Streptomycin in Pregnancy

One of the greatest developments in anti-tuberculosis therapy was the discovery of streptomycin. It was demonstrated over 20 years ago that streptomycin did cross the placental barrier. The present report by Conway and Birt concerns 17 children, ages 6-13, whose mothers received streptomycin while these children were in utero.[4] The study revealed that eight had some abnormalities of eight-nerve function, caloric tests being abnormal in six and audiograms in four. Fortunately, none of the children had a hearing loss in the speech frequencies on the audiogram, and all performed without hearing loss in normal daily activities. The authors draw two conclusions from their study in recommending that such children should have eight-nerve studies before receiving any further streptomycin in the future because they may be inherently susceptible to it and that further work is needed to evaluate fetal risks from streptomycin.

BIBLIOGRAPHY

1. Poller, L., Thomson, J. M.: Reduction of "Rebound" Hypercoagulability by Gradual Withdrawal ("Tailing Off") of Oral Anticoagulants, *Brit. Med. J.* 5448:1475-1476, 1965.
2. Brookes, V. S., Waterhouse, J. A. H., Powell, D. J.: Carcinoma of the Stomach: a 10-year Survey of Results and of Factors Affecting Prognosis, *Brit. Med. J.* 5450:1577-1583, 1965.
3. Birkett, D. A., Apthorp, G. H., Chamberlain, D. A., Hayward, G. W., Tuckwell, E. G.: Bilateral Upper Thoracic Sympathectomy in Angina Pectoris: Results in 52 Cases, *Brit. Med. J.* 5455:187-190, 1965.
4. Conway, N., Birt, B. D.: Streptomycin in Pregnancy: Effect on the Foetal Ear, *Brit. Med. J.* 5456:260-263, 1965.

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References: 1. Telfeyan, S. A.: Clin. Med. *70*:1668, 1963. 2. Shepard, H. L.: J. Am. Geriatrics Soc. *11*:363, 1963. 3. Cummings, D. E.; Goodman, R. M., and Steigmann, F.: J. Am. Geriatrics Soc. *12*:161, 1964. 4. Castleman, B., ed.: New England J. Med. *268*:1462, 1963.

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Barbiturate-Amphetamine Control

(The following letter, written to Representative Lee Hamilton, Ninth District, Indiana, is published to provide information concerning barbiturate-amphetamine control.)

Honorable Lee Hamilton
House of Representatives
Washington, D. C. 20515

Dear Mr. Hamilton:

This is in reply to your recent request for comment on the requirements of the Drug Abuse Control Amendments of 1965 to the Federal Food, Drug, and Cosmetic Act, specifically with respect to the phrase "in any amount" as used in the amendments and the delivery to minors of the drugs covered by this law.

These amendments do include the phrase "in any amount" in defining the term "depressant or stimulant drug." However, they provide for exemption from their requirements for any drug which does not have a potential for abuse and any drug which may lawfully be dispensed without prescription. Further, this law does not prohibit legitimate medical use of any drug subject to it, but calls for procedures to prevent their illegal nonmedical use.

In this connection, *The Federal Register* of January 8, 1966 exempted from the record-keeping requirement of the act on an interim basis until August 1, 1966, (1) drugs subject to the act which may lawfully be sold without prescription, and (2) drugs containing amphetamines or barbiturates combined with other drugs. This exemption is not, however, applicable to amphetamines combined with barbiturates without any other drug.

The law does not prohibit the dispensing of depressant or stimulant drugs to a minor for legitimate medical use; rather, it is intended to ensure that they will be properly used under medical supervision. If, however, these drugs are illegally sold or delivered to a minor by a person over eighteen years of age, the penalties are greater.

If you have some further question, we will be glad to comment more definitively if furnished the specific details.

If we can be of any further assistance, please let us know.

Sincerely yours,
A. D. Davis
Deputy Assistant
Commissioner for Planning

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Medicine At Law

DECISIONS AND OPINIONS

Highlights of recent court actions pertaining to health and medicine from *The Citation* prepared by the Law Division of AMA.

Convictions of Chiropractors for Manslaughter Upheld — The convictions of two chiropractors for manslaughter for having caused the death of a patient through culpable negligence in their treatment of his pulmonary tuberculosis were upheld by a Florida appellate court.

The patient's disease had been diagnosed in 1951 by a physician in whose care he remained for ten years, during which time the disease continued arrested. When an x-ray taken in January, 1962, disclosed that the disease had become active, the physician recommended hospitalization and drug treatment, but the patient refused. He placed himself under the care of the chiropractors. They were both informed that he was suffering from tuberculosis. They treated him without drugs and by a vegetarian diet, interspersed with fasting periods. In May, 1962, he was hospitalized and was given drugs and other approved treatment for the disease by physicians. However, the patient died within a few days.

There was testimony that the treatment the chiropractors gave the patient was not approved medical treatment for one with active tuberculosis, and that, if he had been given available drugs and treated by approved medical methods, his disease could have been arrested or controlled. This evidence was sufficient to support a finding by the jury that the chiropractors' treatment of the patient advanced rather than retarded his tuberculosis infection, and that the treatment amounted to culpable negligence.

The fact that the chiropractors' treatment conformed to generally accepted practices of drugless healers and was rendered in good faith in an effort to help the patient did not bar a finding that their treatment constituted culpable negligence. Nor was there any merit in their contention that their treatment should not have been tested on the basis of the testimony of medical doctors. They also argued that it was not established that their treatment was the proximate cause of the patient's death. The issue of proximate cause was for the jury. There was substantial evidence to support its finding that their culpably negligent treatment caused the patient's death; and they were, therefore, properly convicted of manslaughter, the court said.

Gian-Cursio v. State of Florida, 180 So.2d 396 (Fla., Nov. 16, 1965; rehearings denied, Dec. 9, 1965).

New Jersey Adopts Professional-Liability Screening Plan — A screening plan to evaluate claims of medical negligence has been adopted by rule of the New Jersey Supreme Court, with the approval of the Medical Society of New Jersey and the New Jersey Bar Association.

Under the plan, a claim may be submitted to a panel consisting of two physicians, two attorneys, and a retired judge, as chairman. Great latitude is allowed in the manner of presentation of the claim or defense at the panel hearing. The panel decides only whether there is a "reasonable basis for the claim." No opinion is given as to the extent of damages.

The claimant may, but is not required to, agree in writing that he will not sue if the decision is negative. If he so agrees, and the decision is affirmative, he will be supplied with the names of three expert medical witnesses who are to serve at reasonable fees. If the decision is negative, the attorney for the claimant may not participate in any suit arising out of the claim, but the claimant is not precluded from obtaining another attorney. There is, however, no legal sanction for breach of the agreement not to sue.

It is also provided that all proceedings, records, findings and recommendations of the panel shall be confidential and shall not be used in any other proceedings or be otherwise disclosed without the consent of all parties. It is also provided that no record shall be made of the panel hearings. Also, if medical experts are provided under the plan for appearance in a suit, that fact may not be disclosed.

The main difference between this plan and other similar plans adopted elsewhere seems to be that it is established by rule of court. This will undoubtedly help to assure confidentiality. The agreement not to sue in the event of an adverse decision, although not enforceable legally, is also of interest.

Emancipated Minor's Consent to Surgery Valid — In a suit for damages

against a hospital by a patient for assault in having performed surgery on her, her consent to the surgery was valid, even though she was a minor at the time, and she could not now disaffirm it, a New York trial court ruled.

When she was 19-and-one-half years old, the patient signed a written authorization for a biopsy in connection with the treatment of a skin disorder. At that time she was married and living with her husband. After becoming 21 years old, she brought this suit, claiming that the consent was invalid because she was a minor when she gave it and that she elected to disaffirm it.

When the patient signed the consent, her parents no longer had the guardianship of her person, because of her marriage. A minor may not alter his property rights without the intervention of a guardian or a court, but his control of his personal rights is not so limited. There was nothing to indicate that, when the patient signed the consent, she had not reached the age of discretion or that she was under any physical or mental disability. Her consent was voluntary and constituted the valid exercise of a personal right.

Bach v. Long Island Jewish Hospital, N.Y. Law Journal, (N.Y., Feb. 14, 1966).

Jury Issue Raised in Suit for Diagnosing Pregnancy as Uterine Tumor — In a suit for damages against a physician by a 33-year-old patient for injuries resulting from surgery performed on the basis of the physician's erroneous diagnosis of her pregnancy as a uterine tumor, a trial court erred in directing a verdict for the physician, the Court of Appeals of Kentucky ruled.

In the operation, no uterine tumor was found, but it was discovered that the patient was six to eight weeks pregnant. She suffered a miscarriage 22 days after the operation.

The evidence was insufficient to support a jury finding that the operation was the proximate cause of the miscarriage. The physician testified that the operation "could have" caused the miscarriage. However, there was no medical testimony that it had probably caused the miscarriage. Therefore, the trial court did not err in directing a verdict in the companion suit by the administrator of the child's estate for damages for its wrongful death.

However, the patient's claim was not limited to injuries resulting from the miscarriage, but included some resulting from the operation. The general rule is that professional negligence on a physician's part can be established only by expert testimony that he failed to use the knowledge, skill and diligence ordinarily used by the physicians in the community under like circumstances. The necessary expert testimony can be supplied by the admissions of the physician being sued. There is also the exception that expert testimony is not required where a layman can, on the basis of common knowledge and experience, infer negligence from the facts.

The common knowledge and experience of laymen as to pregnancy is extensive enough to permit them to draw an inference of negligence under the facts of this case. The patient's condition was compatible with pregnancy: she was well within the age limits for pregnancy; the possibility of pregnancy was discussed; a conveniently available, reasonably reliable test for pregnancy was not given; the diagnosis of uterine tumor was not confirmed by any tests or x-rays; and there was no emergency requiring the immediate performance of the operation. It might be said that those facts were not quite enough to sustain a finding of negligence. However, there was the further fact that the physician said, after the operation, that he should have run the pregnancy test. This, combined with the other facts, required the submission of the issue of negligence on the physician's part to the jury, the court said.

Jarboe v. Harting, 397 S.W.2d 775 (Ky., Nov. 19, 1965).

Surgeon and General Practitioner Both Liable for Leaving Hemostat in Patient's Body — A patient in whose abdomen a hemostat was left following gallbladder surgery was entitled to recover damages from both the surgeon and the general practitioner who assisted him in the operation, the Washington Supreme Court ruled.

Several weeks after the operation, the patient suffered severe nausea and abdominal cramping. X-rays disclosed the hemostat's presence. It was removed in a second operation performed by the same surgeon and general practitioner.

There could be no question but that the leaving of the hemostat in the patient's body constituted negligence. A verdict against the surgeon was directed by the trial court. The question of the general practitioner's negligence was submitted to the jury, which returned a verdict against him.

The general practitioner contended that the trial court should have directed a verdict in his favor on the ground that the surgeon was solely responsible for the decision to close the surgical wound. However, as an assistant to the surgeon, he had certain responsibilities and his attention was required to be directed to the incision area throughout the operation. Since the patient was unconscious, she had no way of knowing who left the hemostat in her abdomen. The general practitioner was negligent if he was using the hemostat and failed to remove it. Or if he was not using it, he was negligent in failing to note that the surgeon had not removed it. The converse applied with respect to the surgeon.

The surgeon contended that a verdict should not have been directed against him since either he or the general practitioner could have left the hemostat in the patient's body. When a surgical instrument is left in a patient's body, the surgeon is negligent, as a matter of law, the court said. Further, the surgeon testified that it was his decision to close the surgical incision and his responsibility to make sure that the operative field was clear of foreign objects before doing so.

The general practitioner's requests for instructions that he should not be

held to the standard of care of a specialist in surgery, and that he did not have the responsibility for an instrument count, unless it had been delegated to him by the surgeon, were properly refused. The standard of care for a general practitioner would require him, while assisting a surgeon, to make sure that all instruments had been removed from the patient's body.

Conrad v. Lakewood General Hospital, 410 P.2d 785 (Wash., Feb. 3, 1966).

Fact Issue Raised in Patient's Suit Against Hospital for Heating Pad Burns — In a suit for damages against a charitable hospital by a patient for burns caused by a heating pad, a trial court erred in granting the hospital's motion for summary judgment. The evidence was sufficient to raise an issue of fact as to whether, under the circumstances, the hospital failed in its duty to furnish proper equipment, a Texas intermediate appellate court ruled.

The patient was admitted to the hospital for treatment of low back and head injuries. She was placed under heavy sedation and a heating pad was applied to her back. The heating pad had a manual control by which three different intensities of heat could be obtained. The following morning she was found to have severe burns on her right hip and thigh which had been caused by the heating pad.

Although a charitable hospital cannot be held liable for a patient's injuries caused by its employees' negligence, it can be held liable for a patient's injuries proximately caused by its negligent performance of its nondelegable duty to select and supply proper equipment for the care of its patients. There was evidence that the heating pad was of a type that was commonly used by hospitals and that it would not burn a person if it was on "low" heat. The patient had been instructed to keep the pad on "low." Since the patient had been under heavy sedation, she could not say how the setting had been changed to a heat sufficient to produce her burns. There was also evidence that a particular setting on the type of heating pad used here could be secured by placing a wood or metal object over the control button and covering it with adhesive tape. Burns from this type of pad, no matter at what heat level the control was set, could be prevented by wrapping the pad in a towel or other heavy cloth. There was also evidence that a heating pad had been available for a number of years which, by circulating water through pipes inside the pad, kept it at a preset temperature which could not be changed by the patient because the control was locked. These pads were in use in a number of hospitals in the area.

This evidence was sufficient to raise an issue of fact as to the hospital's negligence, the court said. The heating pad furnished was not reasonably safe for an unconscious patient or one under sedation unless some preventive action was taken to insure that it could not burn the patient. The fact that other hospitals used the same type of pad tended to show that the hospital was not negligent but was not conclusive on the issue. Since a safer type was available and was considered standard equipment by other hospitals, it was for the jury to determine whether the hospital was negligent in failing, under the circumstances of this case, to use the safer type.

Milner v. Huntsville Memorial Hospital, 398 S.W.2d 647 (Tex., Jan. 13, 1966; rehearing denied, Feb. 3, 1966). ◄

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Meprobamate: Drowsiness may occur and can be associated with ataxia, the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor, and respiratory collapse.

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BOOK REVIEWS

CARIES-RESISTANT TEETH

Ciba Foundation Symposium, edited by G. Wolstenholme and M. O'Connor; Little, Brown & Co., Boston, Mass., 1965; 338 pages; $12.50.

In these days of increasing specialization, I have attempted to review books outside the ever-narrowing field of whatever competence I may have. Surely, my dental colleagues will not begrudge my having read this volume; they may find my comments not altogether germane.

Some of the chapters dealt with topics that have general medical significance. It was instructive to see a chapter devoted to "Heredity in Relation to Caries Resistance." Also, "The Chemistry of the Enamel in Relation to Caries Resistance" gave me information in a field altogether new to me.

I found the most intriguing chapter to be the one on "Dental Caries and the Trace Elements." Does fluoridation really re-enforce molybdenum and counteract selenium in the prevention and production of caries? How much do we *really* know as to the whys and wherefores?

Our dental friends should be made aware of this monograph's existence. I do believe that many M.D.'s could pick up this volume in a hospital library and derive benefit from a leisurely thumbing of its pages.

ARNOLD LIEBERMAN, M.D.
New York, N. Y.

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CURRENT CONCEPTS IN MEDICAL PRACTICE

John E. Mullins, M.D., editor; C. V. Mosby Company, St. Louis, Mo., 1965; 436 pages; $10.75.

This neat little volume is intended to be a synopsis of medical literature of the last two years. It is the intention of the authors to offer a "palatable summation of recent developments without exhausting either the subject or the reader."

It is indeed a way to keep up, for none of us can "read it all."

This book is a little uneven: here stressing pathogenesis and there stressing therapy, etc. Such unevenness is a natural consequence of having different authors and discussing various topics.

Subject matter is divided anatomically so that chapters are on eye conditions, cardiovascular disease, pulmonary disease, gastrointestinal disease, liver disease, pyelonephritis, endocrine disease, hematologic disease, neurologic disease, and rheumatoid arthritis and related disorders.

Presumably, only common problems are presented but some seem uncommon to me and my practice.

Do not expect this to be a "cookbook" text such as the various "current" books on therapy. It is more of a synopsis of current medical literature.

ALVIN J. HALEY, M.D.
Fort Wayne

MAST CELLS

Hans Selye, Butterworth Inc., Washington, D.C., 1965; 498 pages; numerous color plates, illustrations and tables; $19.75.

Dr. Selye is best known for his basic formulations anent the stress syndrome. As a corollary of that, he went on to the fascinating work on calciphylaxis (see *JISMA*, 9:1952, 1962). Because the mast cells are intimately involved with these topics, Dr. Selye has come forth now with a massive monograph on the mast cells.

This work is strictly for the dedicated specialist in this field; I doubt that anyone else would tackle the volume. However, there is an "Overview" (pp. 403-404) that summarizes Dr. Selye's ideas on the topic. This plus the superb plates and the chapter on "Theories" I would recommend for perusal. The rest is just too edematous with minutiae.

The publisher has done a superb job with the type, bookbinding and the other parts of his task.

ARNOLD LIEBERMAN, M.D.
New York, N. Y.

THE HEART: ITS FUNCTION IN HEALTH AND DISEASE

Arthur Selzer, M.D.; University of California Press, Berkley and Los Angeles, 1966; 300 pages. (Series-Perspectives in Medicine 1).

This volume is number one in a series to be written to the middle-ground between popular writing of newspapers and magazines and medical or textbook writing. Such a series should be helpful to medical news reporters, paramedical personnel and college or professional people who need background in medical information. Such a series should be helpful to a physician who must address a lay group, teach a lay or paramedical class or otherwise explain medical problems to lay people.

This volume concerns the heart and circulation. It has three parts: one, history of the study of circulation and normal structure and function; two, about diagnosis, treatment and performance in the abnormal heart; and three, concerning various specific heart and circulation diseases. It has several illustrations and diagrams and a good glossary.

This is a fine book for anyone needing supra-newspaper, subtextbook information about the heart and circulation.

ALVIN J. HALEY, M.D.
Fort Wayne

PATHOLOGY FOR THE PHYSICIAN

William Boyd, M.D.; 7th ed., Lea & Febiger, Philadelphia; 1022 pages; profusely illustrated; $18.50.

This newest edition continues the ageless excellence making this THE pathology volume atop my desk for ready reference.

Dr. Boyd has maintained that, "Pathology in the modern sense is not just lesions but physiology gone wrong. . . . A world of disordered function lies revealed in any lesion, if only we have the eye to see it."

It is just this approach that gives clinical value to his meticulously thought-out, compact analyses—and syntheses.

May the foremost teacher of his chosen specialty long continue teaching succeeding generations of students and practitioners the real meaning of the pathology underlying the diseases we have to treat! Until clinical medicine becomes an exact, macromolecular science, there can be no more stimulating approach.

ARNOLD LIEBERMAN, M.D.
New York, N. Y.

Abstracts From Various Literature, Prepared by AMA

IODOPHOR AS A BASIS FOR A NEW DISINFECTANT FOR THE HANDS

T. K. Yap, P. J. De Vries, and M. Knape (Wees-perplein-Ziekenjuis, Amsterdam)

Ned. T. Geneesk. 110:335-339, (Feb. 12), 1966.

Bacteriological tests have been performed with a new disinfectant for the hands based on iodophor. Two methods of washing were compared; rubbing the new preparation into the hands yielded far better results than the usual method of washing.

THE LONG-TERM RESULTS OF TANNER'S "SLIDE" OPERATION FOR INGUINAL HERNIA

J. R. Magarey (Queen Elizabeth Hosp., Adelaide, Australia)

Med. J. Aust. 1:392-395, (March 5), 1966

The internal oblique and transversus muscles forming the conjoined tendon contract and tend to reform the curvature of the lateral border of conjoined tendon, thus pulling it away from Poupart's ligament. Tanner, in 1942, suggested that it might be overcome by abolishing the insertion of conjoined tendon into the linea alba. This he did quite simply by making a vertical incision in that part of the rectus sheath formed by the two muscles concerned—the so-called "Tanner slide maneuver." This allows the lateral border of conjoined tendon to be drawn down to Poupart's ligament with no appreciable tension at all. Tanner's "slide" operation for the repair of inguinal hernia appears to be based on sound anatomical reasoning. This view is tested by a long-term follow-up of 192 patients who underwent such herniorrhaphies, which revealed six recurrences. It is suggested that these recurrences may have been actually attributable to faulty technic at the original operation.

NATURAL COURSE OF GALLSTONE DISEASE

A. Wenckert and B. Robertson (Allmanna Sjukhuset, Malmo, Sweden)

Gastroenterol. 50:376-381, (March), 1966.

All patients (1,501) from the city of Malmo (225,000 inhabitants) in whom cholecystography revealed either gallstones or nonfilling of the gallbladder were followed for 11 years. About 780 patients were not operated on and did not have complications within one year of the roentgen examination. Of these, at least 35% developed complications (severe cholecystitis, icterus or pancreatitis or both, ileus, or cancer) or such severe symptoms that elective cholecystectomy was eventually performed. The risk of late severe symptoms and complications of untreated gallstones seems sufficient to indicate early elective operation even when the gallstones produce only mild symptoms.

PARTIAL EXCHANGE TRANSFUSION IN SEVERE CHRONIC ANEMIA

H. Cutting and A. Marlow (303 E. Chicago Ave., Chicago)

Arch. Intern. Med. 117:478-479, (April), 1966.

The value of partial exchange transfusion in the emergency treatment of potentially lethal anemia is discussed with reference to ten illustrative cases. A simple technic which utilizes readily available materials is used for the exchange.

CRIMINAL PATIENTS WITH XYY SEX CHROMOSOME COMPLEMENT

W. H. Price et al. (Clinical Effects of Radiation Research Unit, Western General Hosp., Edinburgh, Scotland)

Lancet 1:565-566, (March 12), 1966.

The clinical findings in nine men with an XYY sex chromosome complement are described; eight are considered mentally retarded, one is schizophrenic and all have criminal records. No abnormal physical features distinguished these from normal men, but six of the nine were over 6 ft. (181 cm) in height. These patients came under observation through a combination of criminal behavior and diminished responsibility due to mental subnormality or mental illness. The association of these features with the XYY sex chromosome constitution is being investigated; in these investigations their tallness is proving a useful marker.

CHROMOSOME ABNORMALITIES AS PRIMARY EVENTS IN HUMAN MALIGNANT DISEASE: EVIDENCE FROM MARKER CHROMOSOMES

N. B. Atkin and M. C. Baker (Department of Cancer Research, Mount Vernon Hosp., Northwood, Middlesex, England)

J. Nat. Cancer Inst. 36:539-557, (March), 1966.

Observations on the chromosomes of cells from five human malignant tumors are reported. Each tumor had one or more distinctive marker chromosomes. Marker chromosomes were present in a total of 700 of 711 metaphases from these tumors, which included an early malignant lesion of the cervix showing minimal invasion. Two tumors (a stage 4 carcinoma of the cervix and a reticulum cell sarcoma, both untreated) yielded preparations of high quality. The seven best-spread metaphases from the former with the modal number of chromosomes (60) had identical karyotypes, as did 16 from the latter with the modal number of 49. Less extensive data on 13 other tumors, eight of which had marker chromosomes, are also presented. The data presented here, together with the published data on the chromosomes of cells from human tumors, support the view that human malignant tumors frequently but not invariably arise from a single cell in which chromosome changes have occurred. A carcinoma of the corpus uteri, to which brief reference is made, is a possible exception. Most metaphases had apparently normal karyotypes. The role of chromosome abnormalities (particularly structural changes) in the malignant transformation is discussed. Possible parallels between the chromosome findings in the cells of malignant tumors and those in chronic myeloid leukemia are considered. In tumors there may be both specific changes (perhaps involving chromosomes structurally changed) and coincidental changes. Variation in the coincidental changes might largely account for the wide differences between the karyotypes of different tumors.

NEEDLE PARACENTESIS IN BLUNT ABDOMINAL TRAUMA: A CRITICAL ANALYSIS

A. A. Yurko and R. D. Williams (Department of Surgery, Ohio State University Hospitals, Columbus)

J. Trauma 6:194-200, (March), 1966.

Seventy-eight of 278 patients with blunt abdominal trauma seen over the past 16 years had preoperative needle paracentesis. The diagnostic accuracy with this test was 90%. The 60 patients who underwent laparotomy after paracentesis were compared with a slightly larger group of 71 patients requiring surgery for blunt trauma who had no preoperative paracentesis. On an average, surgery was performed three hours earlier, after less blood loss, and with a lower mortality in the patients who had needle paracentesis. Although no effort has been made to specifically interpret false positive or false negative peritoneal aspirations, these findings suggest a definite value to early needle paracentesis in examination of patients with blunt abdominal trauma.

LONG-TERM EFFECTS OF REPEATED PLASMAPHERESIS

L. R. Simson et al. (1335 E. Catherine St., Ann Arbor, Mich.)

Amer. J. Clin. Path. 45:367-372, (April), 1966.

A group of plasmapheresis donors who have donated up to one liter of plasma each week for as long as 32 months have been evaluated clinically and subjected to a variety of laboratory determinations. One donor gave over 550 units of plasma during this interval. In spite of this plasma loss, determinations of serum proteins and serum iron levels, blood cell indices, as well as a variety of other studies, remained stable and within normal limits. Furthermore, no untoward subjective symptoms or physical abnormalities developed. It is concluded that plasmapheresis is a safe and effective technic to enable a blood transfusion service, with a limited number of donors, to provide the large amounts of plasma, plasma components, or platelet preparations required in modern medical practice.

HOSPITAL INFECTIONS CAUSED BY A GROUP OF RECENTLY RECOGNIZED STRAINS OF STAPHYLOCOCCUS AUREUS

I. B. R. Duncan and R. D. Comtois (Microbiology Department, St. Joseph's Hosp., London, Ont.)

Canad. Med. Assoc. J. 94:879-885, (April 23), 1966.

A survey was made of the phage-types of staphylococci responsible for cross-infection in a large Canadian Veterans Hospital between 1961 and 1964. An earlier survey had shown that in 1959 most of the infections were caused by staphylococci of the "80/81/82" group. In 1961 a new group of staphylococci was first recognized and temporary named "atypical group III" strains; these were non-typable by the usual typing phages but showed inhibition patterns with some of the group III phages. The "atypical group III" staphylococci all showed one or other of four patterns of multiple antibiotic resistance. By 1963 these resistant "atypical group III" staphylococci had become more frequent than "80/81/82" strains in causing cross-infection, although both groups have continued to cause infections in the hospital. "Atypical group III" strains mainly infected surgical wounds and skin ulcers whereas "80/81/82" strains commonly produced primary skin sepsis such as boils, carbuncles, furunculosis and other similar skin lesions.

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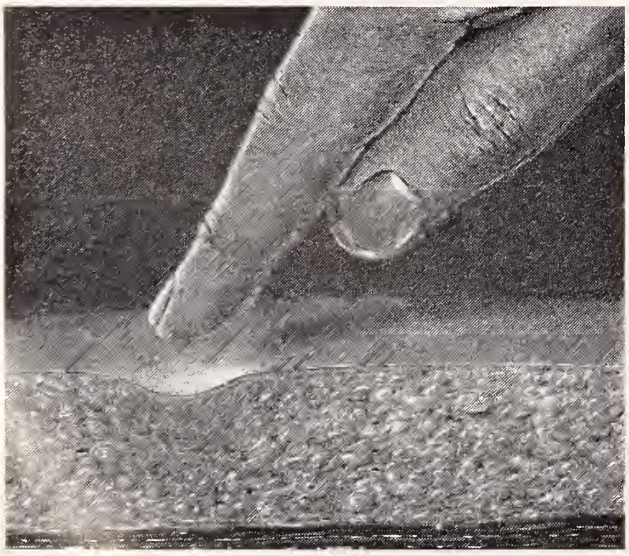

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WARNINGS: Dosage of coadministered antihypertensive agents should be reduced by at least 50%. Use with caution in edema due to renal disease; advanced hepatic disease or suspected presence of electrolyte imbalance. Stenosis or ulcer of small intestine have been reported with coated potassium formulas and should be administered only when indicated. Until further clinical experience is obtained, the use of the drug in pregnant patients should be carefully weighed against possible hazards to the fetus.

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COFFEE AND SERUM LIPIDS IN CORONARY HEART DISEASE

J. A. Little et al. (Sunnybrook Hosp., Toronto)
Lancet 1:732-734, (April 2), 1966.

Significant correlation between coffee drinking and serum lipid and lipoprotein concentrations were found in men with coronary heart disease, but not in healthy controls. Tea tended to have negative correlations with the serium lipids and lipoproteins in the patients. Other nutrients had no consistent correlation in either group. The data suggest that coffee contains a substance which elevates serum lipids in susceptible persons and that such persons may be liable to coronary heart disease.

BILE PERITONITIS IN INFANCY

W. Lees and J. E. Mitchell (Swansea General Hosp., Swansea, Glamorgan, Wales)
Arch. Dis. Child. 41:188-192, (April), 1966.

Two cases of spontaneous perforation of the common bile duct in infancy are reported. This condition may present as an "acute abdomen" when preoperative diagnosis is unlikely or as a chronic condition whose features are (1) alcoholic stools, (2) mild fluctuating jaundice, (3) ascites, and (4) fluid "herniae." The etiology is probably obstruction of the common bile duct from stenosis, stone or inspissated bile. The treatment is laparotomy with simple drainage. By-pass procedures should be adopted only when common bile duct stenosis is complete. The condition is relatively benign provided surgical treatment is instituted. Some sources advance the theory that if the biliary leak is contained by serosal reaction, a choledochal cyst might be formed. ◄

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AMA-ERF Contribution Distributed to Schools

The American Medical Association Education and Research Foundation distributed its annual "no-strings-attached" contribution to the medical schools of United States and Canada in April.

Indiana University School of Medicine received $27,748. The total amount sent this year to 108 schools was $1,133,583. This represents the contributions of physicians and women's auxiliaries in 1965. Since 1951, the fund has distributed $16.6 million to medical schools.

Dr. A. G. Hahn Honored

Albert G. Hahn, who served as administrator of the Deaconess Hospital in Evansville for 42 years before retiring and receiving the title of administrator emeritus in 1964, has been honored by the Deaconess medical staff. A bronze bust of Mr. Hahn was presented to the hospital. It will be given later to the Evansville Museum.

"It's Not Too Late to Stop Smoking Cigarettes" Pamphlet Available

"It's Not Too Late to Stop Smoking Cigarettes" is the title of Public Affairs Pamphlet No. 386, authored by the science writer Alton Blakeslee. The 20-page pamphlet is illustrated. It is written for lay consumption and is designed to aid in breaking the habit.

The pamphlet may be obtained for 25 cents a copy (quantity rates available) from the non-profit educational Public Affairs Committee, 381 Park Avenue South, New York City 10016.

Dr. Bondurant is Speaker

Dr. Stuart Bondurant, Indianapolis, was a participant in a panel discussion on Cardiopulmonary Aspects of Space Travel which was presented at the annual meeting of the American College of Chest Physicians in Chicago, immediately prior to the AMA meeting.

Booklet Lists Opportunities for PHS Hospital Residency Training

Opportunities for physicians to receive residency training in Public Health Service hospitals are described in a new illustrated booklet issued by the PHS.

The hospitals have expanded their training programs and now have about 230 residency positions for physicians. Further expansion is planned. The training is offered in the general hospitals in Baltimore, Boston, Detroit, Galveston, New Orleans, Norfolk, San Francisco, and Seattle, and on Staten Island, New York; and in two large Indian hospitals in Phoenix, Ariz., and Gallup, N. Mex.

Physicians may specialize in anesthesiology, dermatology, general practice, internal medicine, obstetrics and gynecology, ophthalmology, orthopedic surgery, pathology, pediatrics, preventive medicine, radiology, surgery or urology.

The 40-page booklet is entitled "Residencies for Physicians, Public Health Service Bureau of Medical Services," PHS Publication No. 1408. Single copies may be obtained free of charge from the Public Health Service, Department of Health, Education, and Welfare, Washington, D. C. 20201.

Dr. Whitlock Joins Ames Company

Dr. Coleman M. Whitlock, Jr., has joined the Ames Company, Elkhart, as Area Medical Director for the United States. He will be concerned with clinical evaluation of present products and will assist in product research and new product development.

New Bank Charge Account Program for Personal Services

A new program of American Fletcher National Bank is being made available to physicians and dentists in Marion County to allow the AFNB Charge Card to be accepted as payment for personal services.

Similar bank-sponsored charge card programs are being used successfully in other areas of the country by members of the medical profession.

With the AFNB program, you fill out a charge ticket and imprint it with the patient's AFNB Charge Card. These tickets may be deposited daily at your AFNB banking center and your account is immediately credited for the total amount of the tickets less your discount.

The primary benefit to the doctor's office is that all the billing and collecting duties are the responsibility of American Fletcher National Bank.

Dr. Bernoske Appointed

Dr. Daniel G. Bernoske has been employed by the Indiana State Board of Health, Indianapolis, as State Epidemiologist. Dr. Bernoske was formerly at Crown Point and a member of the Lake County Medical Society.

PHS Inaugurates System Of Scholarship Grants

The Public Health Service has inaugurated a system of scholarship grants for students entering professional schools who would otherwise not be able, for financial reasons, to attend college. Grants totaling $3,807,800 have been made to schools of the nation teaching medicine, dentistry, osteopathy, optometry, pharmacy and podiatry.

Each school selects the students and determines the amount of the scholarship which may be as high as $2,500 per year. Indiana University Schools of Medicine, Dentistry and Optometry, Butler University School of Pharmacy and Purdue University School of Pharmacy each received grants under the new system.

Dr. Berman Appointed

Dr. Edward J. Berman has been appointed to the editorial board of *Pediatric Surgery*, the new and official journal for the Surgery Section, American Academy of Pediatrics and the British Association of Pediatric Surgeons.

PANELISTS for a symposium on medical education, moderated by Dr. Thomas C. Moore, Muncie, right, included five noted medical educators who spoke to the American College of Surgeons, Indiana chapter, at Ball State University. They are, left to right, Dr. John Paul North, Chicago, director of the American College of Surgeons (standing); Dr. Glenn W. Irwin, Jr., dean of the Indiana University Medical School; Dr. William H. Knisely, director of the Institute of Biology and Medicine, Michigan State University; Dr. Stafford L. Warren, dean-emeritus, University of California at Los Angeles Medical School; Dr. Robert J. Glaser, vice president for medical affairs and dean of the School of Medicine, Stanford University, and Dr. Moore.

Nation's Medical Schools Too Big, Educators Tell ACS Chapter

Too many of the nation's medical schools are becoming overcommitted. They are too big, three nationally recognized medical educators told members of the Indiana chapter of the American College of Surgeons attending their annual convention at Ball State University.

The three issuing the warning at a symposium on medical education were Drs. Stafford Warren, dean-emeritus of the University of California at Los Angeles Medical School; Robert J. Glaser, vice-president for medical affairs and dean of the School of Medicine at Stanford University, and William H. Knisely, director of the Institute of Biology and Medicine, Michigan State University.

Dr. Warren said that it is "time to create a number of smaller medical schools in states such as Indiana where the population, according to census charts, will provide adequate clinical experiences for quality new schools."

Warren's call for several new schools in Indiana was in sharp contrast to Dr. Glenn W. Irwin, Jr., dean of the Indiana University Medical School, who advocated one centralized medical school system under the direction and control of I.U.

Irwin did say, however, later that "this program (the I.U. plan unveiled last month to the Legislative Study Committee) doesn't preclude the establishment of a second state medical school. It should help not just one but several to establish schools of medicine." The I.U. dean said that the second new state school should be in Bloomington where they have 15 or 16 students on a medical program now.

All panelists, including Dr. John Paul North, director of the American College of Surgeons, were in agreement that new medical schools should be on a university campus.

Glaser, who left Harvard to go to Stanford, said that the California school "attracted me because the medical school is on the campus of a great university. There are all sorts of pluses by being with the behavioral sciences, the mathematicians, the psychologists, the computer center and other facilities," he said.

"The medical faculty and the medical students benefit by their contacts with the rest of the campus, but the undergraduate programs on the campus also benefit," Dean Glaser said. He cited the fact that two Nobel laureates at the Stanford medical school offer a course for undergraduate students only.

Knisely, who will open a medical school for 25 students this fall, said that "The medical school has a real important contribution to make to general education. Physicians have been well educated for a long time and they have a lot to offer other students on the campus."

Dean Irwin said, "All I can do is agree. At the I.U. Medical Center we are separated from the campus by 50 miles and it has been a disadvantage. I hope it will be corrected when there is a campus across the street from us."

Dr. Warren asked the surgeons: "Why wait until you have $25 or $30 million to start a new medical school when you can start with $3 million and utilize private funds. To wait for federal funds will only diminish private support because private donors won't move in and pick up the tab if they think the federal government is going to pay for the medical school." Warren advocated a four-point program to get a small, modest medical school in operation which could start with a class of 24 students the first year.

The UCLA medical school dean's plan, which he has recommended to Boise, Idaho, and Amarillo, Texas, calls for a four-way contract or formation of a separate medical school foundation involving a Veterans Administration hospital, a community hospital, a college or university and a foundation. He said that a $3 million endowment fund should be created, the interest of which would provide $100,000 to hire a medical school dean or director and get the program started.

Warren said that VA hospitals can provide some of the clinical facilities of a teaching hospital and such key faculty as surgeons, radiologists, pathologists, psychiatrists and other nucleus faculty for a medical school program. The UCLA dean warned that the teaching, research and the supervision of the clinical experience for medical students in VA or community hospitals should be under the direction of the university involved.

FELLOWS in the Indiana chapter of the American College of Surgeons elected Dr. Harold D. Caylor, Bluffton, right, new president at the annual state meeting at Ball State University. Dr. Joseph Finneran, Indianapolis, left, was named president-elect and Dr. Justin E. Arata, Fort Wayne, was re-elected secretary-treasurer.

"You can start modestly at $3 million and build your program as you get the money," Warren said. "I'm a firm believer in paying for things as I go. You don't need a marble hall to do a good job," he said. Warren indicated that one-story buildings of 30-year duration would be adequate to start a medical school, provided that supporting help and hospital facilities are already available. For an entering class of 24 students, the former advisor to Presidents Kennedy and Johnson said it would take a minimum faculty of 30 — two in each of 15 departments with an annual faculty budget for salaries and research of $1,250,000.

The Indiana chapter of the American College of Surgeons elected Dr. Harold D. Caylor, Bluffton, to succeed Dr. Joseph B. Davis, Marion, as president. Dr. Joseph Finneran, Indianapolis, was named president-elect and Dr. Justin E. Arata, Fort Wayne, was re-elected secretary-treasurer. Dr. Thomas C. Moore, Muncie, was elected councilor.

Plans Completed to Name Visiting Lilly Lecturer to England

Plans have been completed for the annual appointment of a visiting Lilly lecturer to the Royal College of Physicians, London.

Lilly Industries Limited, a United Kingdom affiliate of Eli Lilly and Company, will annually provide 2,000 pounds sterling (about $5,600) so that the Royal College can invite to the U.K. someone who has made an outstanding contribution to medicine. During his stay in that country he will deliver one lecture at the college and one or more outside London. He will also be presented with a commemorative medal.

This new lectureship is similar to one established by Eli Lilly and Company in 1954 for the American College of Physicians. Since that date, 13 eminent researchers from seven countries have presented papers at the American College's annual conferences.

The Royal College's first Lilly lecturer will be named later this year.

Indiana Boys Win AMA "Award Of Merit" Citations at Dallas, Texas

Indiana boys won two of the two "Award of Merit" certificates presented by the AMA at the 17th International Science Fair in Dallas, May 11-14. Dean George Christakis (17), 324 Chase Street, Gary, and John C. Jackson (17), Box 165, Seelyville, received the honors for their respective studies on "New Concept on Ribonucleic Acid-Induced Transformations on Ascites Tumor Cells" and "Applications of Calciphylaxis."

They were selected by a special AMA committee from the AMA Council on Postgraduate Programs from among 419 finalists from 48 states, Canada, Costa Rica, Japan, the Philippines, Puerto Rico, Sweden and West Germany. The award was presented at the health awards program by Dr. James Z. Appel, AMA president, Lancaster, Pennsylvania. Co-hosts were the AMA, the American Dental Association, the American Pharmaceutical Association and the American Veterinary Medical Association.

Association Members Enrolling In Disability Insurance Program

Members of the Indiana State Medical Association currently are enrolling in the new income replacement plan sponsored by the association. This is a monthly disability insurance program authorized by the House of Delegates and is the first such plan ever sponsored by the association.

Selected to administer the plan is J. Russell Townsend, Jr., C.L.U., a highly experienced insurance specialist, who worked with the Commission on Economics and Insurance for several months in developing the coverage. His office is 811 Board of Trade Building, Indianapolis.

The insurance company is the Continental Casualty of Chicago, and it is of some interest to note that the late Thomas A. Hendricks, former state secretary of the ISMA, assisted in developing the preliminary details of the program when he was in the Continental's home office in 1963 and 1964.

Mr. Townsend and his associates have sent several mailings to all members and are planning additional programs to bring the plan before county societies and hospital staffs.

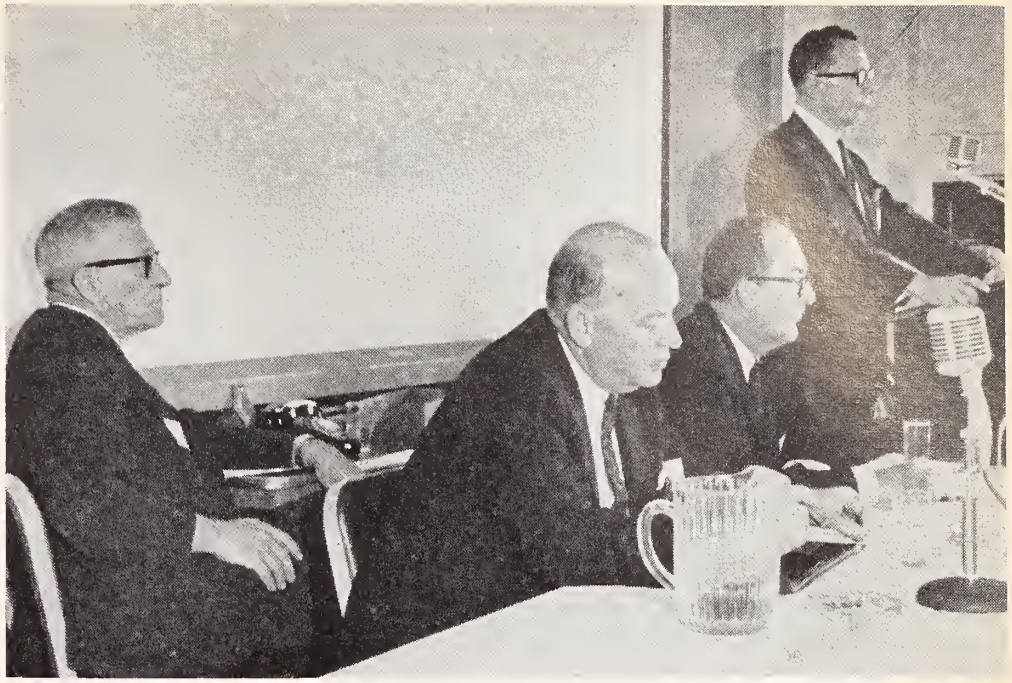
The insurance plan is designed to supplement other similar insurance owned by the physician. Mr. Townsend points out that inflation and increasing office and other expenses make it desirable to increase disability income benefits in the case of many doctors. The plan is not intended to replace existing good plans.

Depending on the age of the physician, monthly benefits up to $800 may be purchased under the program, and the most popular schedule among the hundreds of members who already have enrolled is the "lifetime from accident and five years from sickness" plan.

Inquiries concerning the insurance may be sent direct to Mr. Townsend or to the association office. Members are urged to review their own disability protection and consider this sponsored plan.

Dr. Bondurant Named

Dr. Stuart O. Bondurant, Indianapolis, will continue as editor of *Clinical Research*, the official publication of the American Federation for Clinical Research, according to an announcement made at the federation's annual meeting recently.



NORMAN R. Booher, M.D., (left) chairman of the Indiana State Medical Association's Commission on Voluntary Health Agencies, listens along with Robert A. Rosekrans, assistant director, Community Health Service Activities, AFL-CIO, Washington, D.C. and Glenn W. Irwin, Jr., M.D., dean of the Indiana University School of Medicine as Mr. Leo R. Brown, assistant to the executive vice-president of the American Medical Association, discusses "Voluntarism And Health" before an audience of 450, April 28 in the Severin Hotel.

First Annual Medicine and Voluntary Health Day Inaugurated

The first annual Indiana Medicine and Voluntary Health Day was held at the Severin Hotel in Indianapolis Thursday, April 28.

The program which was sponsored by the state medical association's Commission on Voluntary Health Agencies and Indiana's Voluntary Health Agencies recognized by the commission, attracted approximately 450 laymen and physicians. Norman R. Booher, M.D., Indianapolis, chairman of the commission, presided over the afternoon session and moderated the questions which were asked of the speakers by representatives of various media throughout the state.

Speakers and subjects included John W. Cashman, M.D., chief, Division of Medical Care Administration, Public Health Service, Washington, D.C. who spoke on Medicare and Robert A. Rosekrans, assistant director, Community Service Activities, AFL-CIO, Washington, D.C. who gave labor's view of new federal health programs.

Other speakers included Glenn W. Irwin, Jr., M.D., dean of the Indiana University School of Medicine, who reviewed Indiana University's projected plan for greater medical educational programming in Indiana and Leo Brown, assistant to the executive vice-president of the American Medical Association who concluded the afternoon session on the subject "Voluntarism and Health."

Media representatives who interrogated the speakers following their talks were Harrison Ullmann, science writer of *The Indianapolis Star;* Mrs. Helen Ryan, director of Special Events, WTHI-TV, Terre Haute; Walton R. Collins, associate editor, *South Bend Tribune* and Jerry Huddleston, science writer, *Ft. Wayne Journal Gazette.*

In his comments to the group, Mr. Leo Brown pointed out that the voluntary health associations in the U.S. had pioneered in educating the public in prevention and treatment of disease. He further pointed out "with federal government and state government getting more involved in research, education, community health projects and the health of the individual, many of our citizens are asking the question 'why should I contribute to voluntary health projects? . . .'"

In answer to this question, Mr. Brown said that while government has consistently increased its contribution to health and welfare programs, it would be totally impossible for government to absorb the services now supported by voluntary contributions since it would diminish from millions of givers a feeling of personal participation in helping others. It would seriously affect the lives of that almost equally large group, both givers and workers, who organize and carry out the programs and activities of voluntary efforts in the field of health.

"The loss of these satisfactions" he said, "and opportunities would in itself be a serious consequence should the voluntary effort be completely abdicated and turned over to government." He pointed out further, "I, personally, feel that in our modern social structure, all too much emphasis is being attached to the recipient and his material and physical needs in contrast to the value accrued to those who give their time and talents in helping others."

The program, which was held as an extension of the Indiana Public Health Association's annual meeting, was planned by a sub-committee of physicians and voluntary health leaders under the direction of Dr. Booher. Serving on this first planning committee were William C. Wilson, executive director of the Indiana Tuberculosis Association who acted as chairman; and executives of voluntary health associations, including Earl B. Beagle, Indiana Heart Association; N. H. Keljik, United Cerebral Palsy of Indiana, Inc.; John L. Ewing, Jr., American Cancer Society, Indiana Division, Inc.; Mrs. Robert J. Schultz, National Multiple Sclerosis Society; M. O. Jeglum, Indiana Society for Crippled Children and Adults, Inc. and Joseph R. Brown, Indiana Association for Mental Health.

Serving on the committee from the Indiana State Medical Association were Kenneth W. Bush, ISMA administrative assistant; William A. Karsell, M.D.; Robert Acher, M.D. and James H. Gosman, M.D., all members of the Commission on Voluntary Health Agencies.

Arthritis Information Pamphlet Has Been Revised, Republished

"Today's Facts About Arthritis", the information pamphlet of The Arthritis Foundation, has been revised and republished. It is designed to correct misinformation and ignorance in regard to arthritis, and to establish hopefulness concerning its treatment.

Since many arthritis sufferers are the victims of quackish and fraudulent "remedies" at the hands of unscrupulous persons, genuine medical facts and reliable medical advice contained in the pamphlet will promote good medical treatment and gain for arthritis victims the most efficacious treatment and management possible. Copies of the pamphlet are available without charge from the Arthritis Foundation, Box 2525, New York City 10001; or from the Indiana Chapter of the Foundation, 615 N. Alabama, Indianapolis.

FUTURE MEETINGS, SEMINARS, COURSES

Flying Physicians Association Will Meet September 11 to 16

The Flying Physicians Association will meet at the Dunes Hotel in Las Vegas, Nevada, on September 11 to 16. Scientific sessions will be devoted largely to discussions of various medical disciplines as they relate to general aviation.

Membership is open to all licensed physicians who are members of medical societies approved by the board of directors. National membership now exceeds 1,800, of whom 117 belong to the Indiana chapter. Dr. Louis Byrne, Bloomington, heads the Indiana chapter.

General Practice Review Course Set By University of Colorado

A General Practice Review will be the subject of a week-long postgraduate medical course to be conducted at the University of Colorado School of Medicine, in Denver, from July 18 to 23.

Starting on Monday and ending on Saturday, each day will be devoted in succession to medicine, pediatrics, surgery, trauma, obstetrics and gynecology, and dermatology. Any day, combination of days, or the entire week may be chosen. Full information and detailed program may be obtained by writing: Office of Postgraduate Medical Education, School of Medicine, 4200 E. Ninth Ave., Denver 80220.

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M. C. Pitkin, M.D.
Medical Director

J. W. Gibbs, M.D.
Associate Medical Director

Annual Otolaryngologic Assembly Will be October 1-7 at Chicago

The Annual Otolaryngologic Assembly of 1966 will be held October 1 through 7 in the new Illinois Eye and Ear Infirmary at the Medical Center, Chicago.

The Department of Otolaryngology of the College of Medicine of the University of Illinois offers a condensed postgraduate basic and clinical program for practicing otolaryngologists. It is designed to bring to specialists current information in medical and surgical otorhinolaryngology.

Interested physicians should direct communications to: Department of Otolaryngology, P. O. Box 6998, Chicago, Illinois 60680.

Pan-Pacific Surgical Association Sets 10th Congress in Honolulu

The Pan-Pacific Surgical Association will hold its 10th Congress in Honolulu September 20 to 28 and is planning a Mobile Educational Seminar from September 28 to October 10 for Japan and Hong Kong, and from September 28 to November 1 for those who also wish to visit The Philippines, Thailand, India, Singapore, Australia and New Zealand.

For full particulars write the Association at Alexander Young Bldg., Honolulu 96813.

New SKF Representative

Robert K. Grant will be the Professional Service Representative for Smith Kline & French Laboratories in the Lafayette territory. He is a graduate of the University of Missouri.

Dr. Russell Elected

Dr. John R. Russell, Indianapolis, has been named president-elect of the Congress of Neurological Surgeons.

Lederle Will Remit Difference In Welfare Patients' Drug Cost

In order to preserve the time-honored physician-patient relationship and allow physicians to write prescriptions for drugs of their choice without burdening welfare administrations financially, Lederle Laboratories will remit to a state welfare department the price differential between the Lederle price to a retail pharmacist and the Lederle price to city-county-state institutions. The policy is also designed to avoid the tendency toward prescribing products of lesser quality in the name of economy.

AMA Committee on Maternal and Child Care Sponsors National Conference

A National Conference on Infant Mortality is being sponsored by the American Medical Association's Committee on Maternal and Child Care. The conference will be held on August 12-13, at the Fairmont Hotel in San Francisco, California.

An open invitation to attend is being extended to chairmen and members of all state and county Maternal and Child Care; Perinatal and Maternal Mortality Committees; State Health Department Directors of Maternal and Child Health; medical school faculty members in Departments of Obstetrics and Gynecology, Pediatrics, and Preventive Medicine. Other interested physicians and representatives of

groups concerned with the problems of infant mortality are also invited to attend.

The program has been planned to explore effective approaches for continuing the reduction of infant mortality. Special workshops will be arranged to discuss the identification of high risks, organization and delivery of special care services, manpower utilization, continuity of reproductive care and problems of prematurity. Other subjects to be covered by special speakers will include perinatal mortality studies, obstetric and pediatric education programs, research questions, expectant parent and sex education, and population control.

Those interested in receiving further information about registration for the conference should write the Secretary, Committee on Maternal and Child Care, American Medical Association, 535 N. Dearborn St., Chicago, Illinois 60610.

Joint Scientific Meeting Planned for San Francisco August 28-September 2

The American Congress and the American Academy of Physical Medicine and Rehabilitation will hold a joint scientific meeting and separate business meetings at the Sheraton-Palace Hotel, San Francisco, August 28 to September 2.

Social events are planned for each day in addition to special activities for the ladies auxiliary and supervised program for children.

Eighth National Conference on The Medical Aspects of Sports

The Eighth National Conference on the Medical Aspects of Sports, sponsored by the American Medical Association under the auspices of its Committee on the Medical Aspects of Sports, will be held in Las Vegas, Nevada, at Caesar's Palace on November 27. The conference is held annually in conjunction with and on the first day of the Clinical Convention of the American Medical Association.

The conference is open to key nonmedical athletic personnel as well as interested physicians. Those who would like to receive further information concerning the conference should address the Secretary, Committee on the Medical Aspects of Sports, American Medical Association, 535 N. Dearborn St., Chicago, Illinois 60610.

13th Western Cardiac Conference Will be August 24-26 at Denver

The 13th Western Cardiac Conference will be held on August 24, 25 and 26 at the University of Colorado Medical Center in Denver. The subject for discussion is ischemic heart disease.

Full information may be obtained by writing the Colorado Heart Association, 1375 Delaware St., Denver 80204.

Technicon International Symposium on Automation to be October 17-19

The Technicon International Symposium on Automation in Analytical Chemistry will be held at the Statler-Hilton Hotel, New York City, on October 17, 18 and 19.

Write Jerome E. Golin, Technicon Instruments Corporation, New York City 10502 for further information.

Laryngology, Bronchoesophagology Course October 31 to November 12

The Department of Otolaryngology of the Illinois Eye and Ear Infirmary and the College of Medicine of the University of Illinois at the Medical Center, Chicago, will conduct a postgraduate course in laryngology and bronchoesophagology from October 31 through November 12.

This course is limited to fifteen physicians and will be under the direction of Paul H. Holinger, M.D. It will be held largely at the new Illinois Eye and Ear Infirmary, 1855 West Taylor Street, Chicago, and will include visits to a number of Chicago hospitals. Instruction will be provided by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures.

Interested registrants will please write directly to the Department of Otolaryngology, College of Medicine of the University of Illinois at the Medical Center, P. O. Box 6998, Chicago, Illinois 60680.

Course in Gastroenterology Offered in Philadelphia in October

The annual postgraduate course in Gastroenterology of the American College of Gastroenterology will be given at the Bellevue Stratford in Philadelphia on October 27 to 29.

The subject matter to be covered, from the medical as well as the surgical viewpoint, will be essentially the diagnosis and treatment of gastrointestinal diseases and comprehensive discussions of diseases of the esophagus, stomach, pancreas, liver and gallbladder, small intestine and colon. A session on instrument technics will be held at the Albert Einstein Medical Center.

For enrollment and more information write American College of Gastroenterology, 33 W. 60th St., New York City 10023.

AMA Congress on Occupational Health Will Meet in September

The AMA Congress on Occupational Health will meet this year in Portland, Oregon on September 26 to 28. It will be in conjunction with the annual session of the Oregon Medical Association, as it was with the ISMA annual convention last year.

Details are obtainable from the AMA Council on Occupational Health, 535 N. Dearborn, Chicago 60610. ◄

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BOX 328

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☐ **CLINICAL RESEARCH**

Position of responsibility involves establishing and supervising the clinical trials of new drugs, analysis of results and preparation of reports. (Travel) within the U.S. 20% of the time.

Annual Meeting Dates of Professional Medical and Allied Organizations

AMERICAN MEDICAL ASSOCIATION CLINICAL MEETING
Date November 27-30
Place Las Vegas, Nevada

INDIANA HOSPITAL ASSOCIATION
Date Nov. 2-4
Place Marott Hotel, Indianapolis

NORTHERN INDIANA PSYCHIATRIC SOCIETY
Date Fourth Wednesday of every month, September through June
Place For location and program, inquire Beatty Memorial Hospital, Westville

INDIANA NEUROPSYCHIATRIC ASSOCIATION
Date Second Wednesday of every month, October through May
Place The Athenaeum, Indianapolis

INDIANA STATE MEDICAL ASSOCIATION CONVENTION
Date October 10-13, 1966.
Place French Lick, Indiana

INDIANA PUBLIC HEALTH ASSOCIATION
Date April 26-27, 1967
Place Indianapolis

INDIANA OBSTETRICAL AND GYNECOLOGICAL SOCIETY
Date November 2, 1966
Place Howard Johnson's (downtown), Indianapolis

INDIANA ROENTGEN SOCIETY
Date May 7, 1967
Place Indianapolis

INDIANA ACADEMY OF GENERAL PRACTICE
Date May 3-4, 1967
Place Murat Temple, Indianapolis

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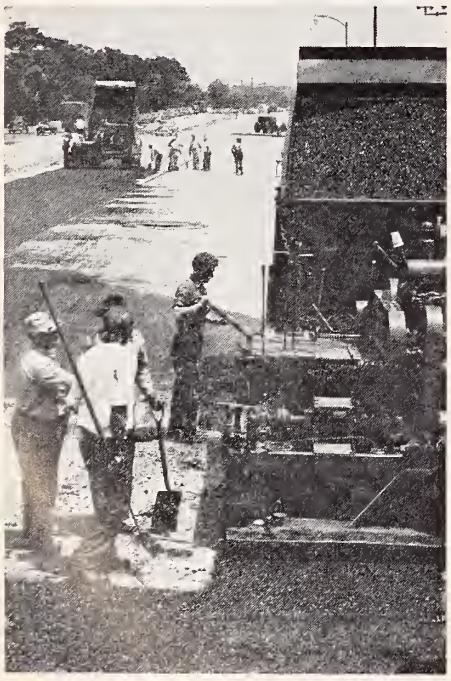

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A razor-thin layer of only 10 microns adheres tenaciously to the skin for hours, yet washes off easily with soap and water. Virtually invisible, RVP-Elder is odorless, non-staining, and perspiration and water resistant, even while swimming. No sensitivity has been encountered.

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Write for clinical trial package and absorption spectrum
References: (1) Schoch, A. G.: Current News in Dermatology, August, 1963; (2) Jillson, O. F., and Baughman, R. D.: Arch. Dermat. 88:409, 1963; (3) Cole, H. N., et al.: J.A.M.A. 130: 1, 1946; (4) MacEachern, W. N., and Jillson, O. F.: Arch. Dermat. 89: 147, 1964.
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INDIANA STATE BOARD OF HEALTH

MONTHLY REPORT—May, 1966

Disease	May 1966	Apr. 1966	Mar. 1966	May 1965	May 1964
Animal Bites	1135	844	884	1179	1068
Chickenpox	344	481	871	312	483
Conjunctivitis	140	134	469	126	142
Diphtheria	1	0	0	0	0
Dysentery, Unspecified	33	35	52	158	45
Gonorrhea	303	368	492	438	325
Impetigo	65	68	150	118	69
Infectious Hepatitis	30	34	56	56	35
Infectious Mononucleosis	52	98	88	64	62
Influenza	869	1694	3885	278	202
Measles (Rubeola-Rubella)	1681	1456	1591	705	5019
Meningitis, Meningococcal	16	12	18	5	2
Meningitis, Other	5	2	3	8	7
Mumps	250	402	671	285	751
Pertussis	18	9	19	6	41
Pneumonia	607	548	669	133	200
Poliomyelitis	0	0	0	0	0
Streptococcal Infection	606	1178	2571	463	468
Syphilis					
Primary & Secondary	14	4	4	5	1
All Other Syphilis	95	94	105	103	98
Tinea Capitis	4	13	55	5	14
Tuberculosis (Active)	76	59	128	83	101

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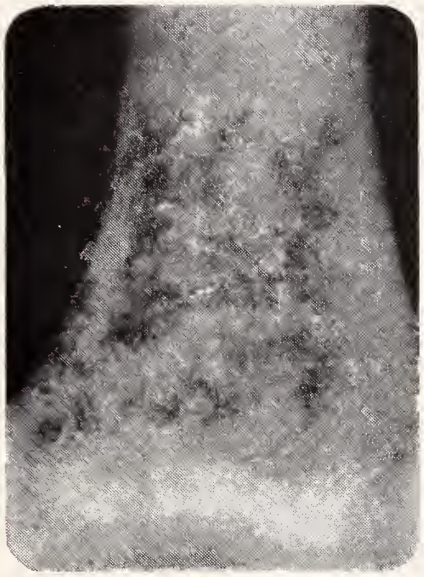

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Contraindications: Tuberculosis of the skin, herpes simplex, chicken pox and vaccinia.

Precautions and Side Effects: Do not use in the eyes or in the ear (if drum is perforated). A few individuals react unfavorably under certain conditions. If side effects are encountered, the drug should be discontinued and appropriate measures taken. Use on infected areas should be attended with caution and observation, bearing in mind the potential spreading of infection and the advisability of discontinuing therapy and/or initiating antibacterial measures. Generalized dermatological conditions may require systemic corticosteroid therapy. Steroid therapy, although responsible for remissions of dermatoses, especially of allergic origin cannot be expected to prevent recurrence. The use over extensive body areas, with or without occlusive nonpermeable dressings, may result in systemic absorption. Appropriate precautions should be taken. When occlusive nonpermeable dressings are used, miliaria, folliculitis and pyodermas will sometimes develop. Localized atrophy and striae have been reported with the use of steroids by the occlusive technique. When occlusive nonpermeable dressings are used, the physician should be aware of the hazards of suffocation and flammability. The safety of use on pregnant patients has not been firmly established. Thus, do not use in large amounts or for long periods of time on pregnant patients.

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County, District News

Second District

Dr. Joe Dukes, Dugger, was named councilor-elect of the Second District Medical Society when it met June 9 in Washington, Ind. Dr. J. S. Brown, Carlisle, was re-elected secretary; the president will be elected by the Greene County Medical Society.

Third District

The Third District Medical Society met May 17 at French Lick. Dr. Daniel H. Cannon, New Albany, was elected president and Dr. Elmer L. Wallace, New Albany, secretary. Tentative date for the 1967 meeting is May 17 with Floyd County as host.

Fourth District

Dr. Harold W. Richmond, Columbus, was elected president of the Fourth District Medical Society when it met May 3rd at Madison. Other newly-elected officers are: Drs. Kenneth Bobb, Seymour, vice-president; David L. Adler, Columbus, secretary and Joseph M. Black, Seymour, re-elected Blue Shield Board member.

Fifth District

Physicians of the Fifth District Medical Society elected Dr. John Ellett, Jr., Coatesville, president; Dr. Richard Veach, Bainbridge, secretary-treasurer and Dr. Wilbert McIntosh, Riley, as councilor at its June 8 meeting at Clinton. May 17 has been chosen for the meeting next year at Greencastle.

Sixth District

The Sixth District Medical Society met April 27 at Rushville to elect Dr. John J. Farrell, Jr., Greenfield, president; Dr. Paul Inlow, Shelbyville, vice-president and Dr. Stephen Smith, Knightstown, as secretary.

Eighth District

Newly-elected president of the Eighth District Medical Society is Dr. Donald E. Spahr, Portland. The society, meeting June 1, also elected Dr. J. F. Vormohr, Portland, as secretary. The 1967 meeting will be June 7 at Portland.

Ninth District

The Ninth District Medical Society met May 19th at Fowler. The Tipton county Medical Society will be host for the 1967 meeting on May 18th.

Tenth District

Dr. Herman Wing, Gary, was elected alternate councilor and Dr. Milton Gevirtz, Munster, elected to the Blue Shield Board at the May 11 meeting of the Tenth District Medical Society.

Twelfth District

Physicians of the Twelfth District Medical Society elected Dr. Warren L. Niccum, Columbia City, as president at the May 18 meeting in Bluffton. Others elected were: Drs. Frederic L. Schoen, Fort Wayne, vice-president and Kenneth Isenogle, Fort Wayne, secretary-treasurer. The next meeting date will be May 17, 1967, at Fort Wayne.

Boone

Field Secretary Howard Grindstaff met May 3 with members of the Boone County Medical Society to discuss utilization review plans. Fourteen members attended the meeting.

Dearborn-Ohio

Drs. Merritt O. Alcorn and Elton Heaton, pathologists from Madison, discussed the new computer methods of doing laboratory work at the May 5 meeting of the Dearborn-Ohio County Medical Society.

Elkhart

Dr. David Yi-Yung Hsia, head of the biochemistry and genetics department at Children's Memorial Hospital in Chicago spoke on "Inborn Errors of Metabolism" at the May 5 meeting of the Elkhart County Medical Society.

Fort Wayne

Newly-elected officers of the Fort Wayne County Medical Society are: Drs. Eugene F. Senseny, president; Alvin J. Haley, president-elect; James E. Shaw, secretary and Robert J. Schmoll, treasurer.

Grant

Dr. Frederick J. Friederlein, Muncie, discussed "The EEG, its Indications and Interpretations" at the May 24 meeting of the Grant County Medical Society.

Harrison-Crawford

Dr. Louis H. Blessinger is now president and Dr. Carl Dillman, secretary-treasurer of the Harrison-Crawford County Medical Society. Both the new officers are from Corydon.

Henry

Dr. James Meadows, of the I.U. Medical Center, spoke on "Bilirubin, Metabolism, Jaundice" at the May 19 meeting of the Henry County Medical Society. Twenty members attended.

Huntington

New officers of the Huntington County Medical Society are: Drs. Reeve B. Peare, Huntington, president; Barth E. Wheeler, Huntington, vice-president; Carl Ray, Warren, secretary-treasurer; Richard Wagner, Huntington, delegate and Warren Van Campen, Huntington, alternate.

Jackson-Jennings

The Jackson-Jennings County Medical Society met May 2 with Field Secretary Robert Amick to discuss Medicare, welfare, etc. Eighteen members attended.

Jay

Twelve members of the Jay County Medical Society met May 5 with Field Secretary Grindstaff to discuss Medicare and other related subjects.

LaPorte

Dr. Jack Kamen, director of Intensive Care at Mercy Hospital, Gary, spoke on "Intensive Care Units and Their Future" at the May 17 meeting of the LaPorte County Medical Society.

Lawrence

Dr. Richard P. Austin, Bedford, discussed information he had learned from meetings he has attended on Medicare at the May 4 meeting of the Lawrence County Medical Society. Twenty members attended.

Ripley

New officers of the Ripley County Medical Society are: Drs. Bill E. Freeland, president; William J. Warn, secretary-treasurer and Dr. Freeland, delegate.

St. Joseph

The St. Joseph County Medical Society has elected the following as its new officers: Drs. Raymond E. Nelson, president; Samuel E. Bechtold, president-elect; and L. F. Sandock, secretary-treasurer. Delegates are Drs. Sandock, Nelson and Bechtold, W. Robert Orr and Jacob Rosenwasser. Alternates are Drs. W. J. Stodgill, R. A. Ganser, G. D. Colip, Herbert Schiller and George M. Haley.

Shelby

Dr. W. D. Inlow spoke on "Definitions of Medicine" at the May 5 meeting of the Shelby County Medical Society. Seventeen members attended.

Tippecanoe

"Uses and Abuses of Diuretics" was the topic chosen by Dr. Clarence Gantt, of the University of Illinois Medical School, when he spoke at the May 10 meeting of the Tippecanoe County Medical Society.

Washington

Dr. T. Kermit Tower, Campbellsburg, is the new president and Dr. Eddie R. Apple, Salem, secretary-treasurer of the Washington County Medical Society. ◄

Deaths

Clyde R. Burress, M.D.

Dr. Clyde R. Burress, 37, Evansville general practitioner, died April 25 in Norton's Hospital in Louisville, Ky.

Dr. Burress, a native of Kentucky and a veteran of the Korean War, was a member of the Vanderburgh County Medical Society. He was graduated from the University of Louisville School of Medicine in 1957 and served his internship at St. Joseph Infirmary, Louisville. He was on the staffs of Protestant Deaconess, Welborn Baptist and St. Mary's Hospitals at Evansville.

Emor L. Cartwright, M.D.

Dr. Emor L. Cartwright, retired Fort Wayne proctologist, died March 24 in Brownsville, Texas, while on a vacation. He was 78.

He was a native of Payne, Ohio, and began his medical practice in Fort Wayne shortly after World War I. Dr. Cartwright was graduated from Northwestern University in 1912. He was a founder and past-president of the Ohio Valley Proctologic Society; a senior Fellow and former vice-president of the American Proctologic Society; a Fellow of the American College of Surgeons; a diplomate of the American Board of Surgery and member of the Allen County Medical Society.

Joseph H. Clark, M.D.

Dr. Joseph H. Clark, a native of Rossville, died April 28 at Huntington at the age of 55.

A member of the Huntington County Medical Society, Dr. Clark was a practicing physician in Rossville for many years. He was graduated from the I.U. School of Medicine in 1942 and became Chief of Medicine at Huntington County Hospital.

Paul K. Cullen, M.D.

Dr. Paul K. Cullen, a specialist in proctology and Indianapolis physician and surgeon, died April 21 at his home. He was 63.

Dr. Cullen was on the staffs of Methodist and St. Vincent's Hospitals and was a member of the courtesy staff of Community Hospital. Graduated from the I.U. School of Medicine in 1928, Dr. Cullen served his internship and received surgical training at the old Indianapolis City Hospital. During World War II he served in the Navy Medical Corps on Guam. He was a member of the Marion County Medical Society.

Russell B. Engle, M.D.

Dr. Russell B. Engle, 68, Winchester, died April 3 at the Randolph County Hospital where he had been a patient for one day.

Dr. Engle had retired from active practice last year. A lifelong Randolph county resident, Dr. Engle was graduated from the I.U. School of Medicine in 1923. He practiced medicine in Randolph County for 46 years — 24 years at Farmland and 22 years at Winchester. He was a veteran of World Wars I and II and a member of the Randolph County Medical Society.

Paul W. Ferry, M.D.

Dr. Paul W. Ferry, past-president of the Howard County Medical Society and the Kokomo Board of Health, died May 9 at St. Joseph Memorial Hospital, Kokomo. He was 73.

Dr. Ferry, a native of Scipio, was graduated from the St. Louis University School of Medicine in 1921. He was a practicing physician at Kokomo from 1924 until his retirement in 1964. He served two terms as president of Kokomo's Board of Health; headed the county medical society in 1934; was president of the 11th district in 1934 and was a Senior Member of ISMA.

Henry W. Gante, M.D.

Dr. Henry W. Gante, 77, an Anderson physician for more than 50 years, died April 1 at the Veterans Administration Hospital at Marion.

Dr. Gante, an obstetrician, began his practice in Anderson in 1910 after being graduated from the I.U. School of Medicine. A veteran of World War I, Dr. Gante was a Madison County native and had lived in Anderson most of his life. He had been an officer in the Madison County Medical Society for several years and was one of the founders of the 40 & 8 nurses training program, which later became a national project of the 40 & 8. He was a member of the American Academy of Pediatrics for over 35 years; served as surgeon for the New York Central Railroad for 28 years and was a Senior Member and member of the ISMA 50-Year Club.

Paul L. Nelson, M.D.

Dr. Paul L. Nelson, 61, Anderson physician for many years, died April 19 at the Veterans Hospital, Indianapolis.

Dr. Nelson was graduated from the I.U. School of Medicine in 1931 and served in the Army Medical Corps during World War II. He was a member of the Madison County Medical Society.

Daniel S. Quickel, M.D.

Dr. Daniel S. Quickel, who began practicing medicine at Anderson in 1896, died there April 19 at the age of 98.

A member of the Madison County Medical Society, the ISMA 50-Year Club and a Senior Member of ISMA, Dr. Quickel was a retired general practitioner. He was named to the Anderson Board of Works on his 87th birthday; was graduated from the Cincinnati College of Medicine and Surgery in 1894 and was the oldest living alumnus of the college.

Simon Reisler, M.D.

Dr. Simon Reisler, a practicing surgeon in Indianapolis for over half a century, died March 24 at Methodist Hospital. He was 79.

Dr. Reisler, graduated from the Chicago Medical School in 1911, had maintained offices in the Banker's Trust Building, Indianapolis, since 1920. He was on the staffs of Methodist, St. Francis and Community Hospitals before retiring this year. He served with the Army Medical Corps during World War I, was a member of the Marion County Medical Society, the ISMA 50-Year Club and a Senior Member of ISMA.

Penn G. Skillern, M.D.

Dr. Penn G. Skillern, 84, retired South Bend physician, died May 7 in his home after a year's illness.

Graduated from the University of Pennsylvania in 1903, Dr. Skillern was a veteran of World War I, serving as a lieutenant commander in the Navy. He was a Fellow of the American College of Surgeons, specializing in neurosurgery. Dr. Skillern established his practice in South Bend in 1923, going there from the University of Pennsylvania where he had been associate professor of surgery for three years. He retired from active practice about nine years ago, was a member of the St. Joseph County Medical Society, the ISMA 50-Year Club and a Senior Member of ISMA.

Oscar A. Turner, M.D.

Dr. Oscar A. Turner, retired Madison general practitioner, died April 10 at Kings Daughters Hospital at the age of 81.

Graduated from I.U. School of Medicine in 1907, Dr. Turner spent most of his life as a general practitioner in Madison. He interned at Indianapolis General Hospital and did graduate work at Cornell and Columbus Universities. Dr. Turner, retired in 1951, was a member of the Madison County Medical Society and the ISMA 50-Year Club. ◄

Association News

EXECUTIVE COMMITTEE

April 16, 1966

Present: Ralph V. Everly, M.D., chairman; G. O. Larson, M.D.; Kenneth O. Neumann, M.D.; Eugene S. Rifner, M.D.; E. T. Edwards, M.D.; Lester Hoyt, M.D.

Frank B. Ramsey, M.D., editor of The Journal; Robert Hollowell, attorney, and James A. Waggener, executive secretary.

Guest: Frank Woolley, American Medical Association.

Membership Report

Number of members as of December 31, 1965	4,394
1966 members as of March 31, 1966:	
Full dues paying	3,722
Residents and interns	92
Council remitted	42
Senior	308
Honorary	3
Military	35
Total 1966 members as of March 31, 1966	4,202
Number of members as of March 31, 1965	4,187
Gain over last year	15

Number of AMA members as of March 31, 1966	4,097
Total 1965 AMA members as of March 31, 1965	4,091
Gain over last year	6
1966 AMA members: Dues paying	3,621
Exempt, but active	476
	4,097
Number who have paid state dues but not AMA dues as of March 31, 1966	105

Headquarters Office

The request of the Woman's Auxiliary to display the past presidents' pins in a framed case was approved by consent, and the secretary was instructed to notify the auxiliary that a space would be arranged for this purpose.

A report on the tax status of the association, in which the case had been venued to the Johnson County Circuit Court, was made for the information of the committee.

Mr. Hollowell, attorney, reported on the proposal of Barton, Curley & McLaren for a blanket catastrophic liability policy and purchase of this policy was authorized on motion of Drs. Neumann and Larson.

Building Matters

Upon motion of Drs. Edwards and Rifner, leasing of the properties on Pennsylvania Street is to be put into the hands of a realtor or a bank.

Treasurer's Office

The report of the treasurer was approved on motion of Drs. Larson and Edwards.

Annual Convention, French Lick, October 10, 11 and 12, 1966

The program for the annual convention was reviewed.

It was noted that Dr. Kenneth Kohlstaedt could not serve as chairman of the Scientific Exhibits Committee. The selection of a chairman of this committee is to be left to the chairman of the Convention Arrangements Commission.

Legislation

National:

Several matters concerning the implementation of PL 89-97 were reviewed for the information of the committee as well as a letter from the Association legal counsel concerning the resolution adopted by the Indiana Hospital Association.

Local:

The exchange of correspondence between the State Department of Public Welfare and the Allen County Medical Society was reviewed for the information of the committee.

A letter from the Pharmaceutical Manufacturers Association concerning the use of drugs under PL 89-97 was reviewed for the information of the committee.

Organization Matters

A letter from the Dean of the Indiana University School of Medicine concerning the Mark Allen Barnard case was reviewed and by consent it was agreed that this matter had been satisfactorily resolved.

On motion of Drs. Rifner and Edwards, the request of the Commission on Public Health for authorization to use the association name on the publication of the federal government concerning rehabilitation was referred to the Council.

The request of the Commission on Public Health for authorization to reprint 7,000 copies of the "Report on Industrial Practice" was reviewed and it was decided that it should be announced that copies of this would be available on request but that the 7,000 copies should not be printed and distributed on a blanket basis at this time.

The secretary reported that he had been advised since the last meeting by Mr. Harry Latham that the meeting which had been proposed for Gary of the Indiana Nursing Association was to consist of a panel on utilization and he desired a representative of the association to participate as a member of this panel. Upon motion of Drs. Edwards and Larson, the association is to have a member attend this meeting and participate in the panel, and this responsibility should be assigned to the chairman of the Commission on Public Health.

Letters from the Vanderburgh and the Floyd County Medical Societies concerning these county societies' action in regard to the AMA dues increase were read for the information of the committee.

A letter from the American Medical Association, in which was enclosed a check for $27,748.85 from the American Medical Association Education Research Foundation, for use by the Indiana University School of Medicine, was read for the information of the committee.

The secretary reviewed the report of Dr. Dwight Schuster who represented the association at the annual Conference of State Mental Health Representatives, held in Chicago on March 18 and 19, 1966.

The secretary reviewed the report of Dr. M. E. Glock, who represents the association on the Advisory Committee for Medical Assistance for the Aged to the State Department of Public Welfare.

By enthusiastic consent, a letter is to be written to the Hammond Chamber of Commerce for presentation to Dr. E. S. Jones when he is named outstanding citizen of the year by his Chamber.

The announcement that Indiana University School of Education had organized a Department of Rehabilitation Counselors was reviewed for the information of the committee.

The report of the legal counsel concerning the Wabash County case was reviewed for the information of the committee.

Renewal of membership in the United States Chamber of Commerce in the amount of $50.00 was approved by consent.

A letter from the Louisiana State Medical Association announcing that they will nominate Ralph H. Riggs, M.D., for the office of trustee of the American Medical Association, was read for the information of the committee.

Request of Dr. A. C. Offutt for recommendations for appointment of two members to the Advisory Hospital and Health Facilities Planning Council was reviewed and the following physicians are to be recommended: Joseph F. Ferrara, M.D., Franklin; Kenneth L. Olson, M.D., South Bend, and James H. Gosman, M.D., Indianapolis.

A letter from Indiana Health Careers, Inc., asking for the nomination of a representative of the Indiana State Medical Association to serve on its board of directors was reviewed and the names of Lester H. Hoyt, M.D., and John L. Arbogast, M.D., are to be submitted as the association's nominees.

Renewal of membership in the Indiana Conference on Social Welfare was turned down on motion of Drs. Neumann and Rifner.

Request of the Indiana Public Health Association for $25.00 to help defray the cost of a publication was approved by consent.

A letter from the Indiana Municipal League concerning a representative to attend its meeting was reviewed, and upon motion of Dr. Edwards, taken by consent,

Dr. William G. Bannon is to be requested to represent the association as an observer.

Minutes of the March 16, 1966, meeting of the Board of Medical Registration of Indiana were reviewed. On motion of Drs. Edwards and Larson, the medical members of the board are to be requested to meet with the Executive Committee in the near future.

Several items of correspondence concerning Blue Shield were reviewed for the information of the committee.

New Business

Upon motion of Dr. Edwards, taken by consent, the secretary was authorized to purchase 300 sesquicentennial souvenir key chains for distribution to the delegates at the June meeting of the AMA.

The Journal

Request of Wallace Laboratories for the purchase of 81,000 reprints of a product paper which was run in *The Journal* was approved on motion of Dr. Edwards, taken by consent.

Dr. Ramsey asked the opinion of the committee concerning the publication of the annual roster in a later issue of *The Journal*, preferably October or November, and upon motion of Dr. Edwards, taken by consent, the request was approved.

Dr. Ramsey reported on the income of *The Journal*, saying that *The Journal* business is up 24% over the same period a year ago.

Future Meetings

Second National Conference on Health Education of the Public, Chicago, April 14-16, 1966. No representative is to be sent to this meeting.

500 Festival Mayor's Breakfast, April 30, 1966. No representative will be sent.

The president and the executive secretary are to attend the annual meeting of the Illinois State Medical Society in Chicago, May 15-18.

National Conference on Infant Mortality, San Francisco, August 12-13, 1966. The association representative on the Maternal Mortality Study Committee is to be asked if he would like to attend this meeting.

Third National Conference on Medical Quackery, October 7-8, 1966, Chicago. No action was taken on this meeting.

There being no further business, the committee adjourned to meet again on Saturday, June 11, 1966, at 2:00 p.m

THE COUNCIL

April 16, 1966

The Council of the Indiana State Medical Association convened for its spring meeting at 2:00 p.m., Saturday, April 16, 1966, in the headquarters office, 3935 North Meridian St., Indianapolis, with Dr. E. T. Edwards, the chairman, presiding.

Roll call showed the following present:

Councilors:

First District — Gilbert M. Wilhelmus, Evansville, alternate
Second District — E. T. Edwards, Vincennes
Third District — E. L. Wallace, New Albany, alternate
Fourth District — Robert M. Reid, Columbus
Jack E. Shields, Brownstown, alternate (also AMA delegate)
Fifth District — V. Earle Wiseman, Greencastle
A. W. Cavins, Terre Haute, alternate
Sixth District — William R. Tindall, Shelbyville
Seventh District — Albert M. Donato, Indianapolis
Eighth District — Donald R. Taylor, Muncie
Paul W. Sparks, Winchester, alternate
Ninth District — Peter R. Petrich, Attica
Clarence G. Kern, Lebanon, alternate
Tenth District — Lowell H. Steen, Whiting
Lee Trachtenberg, Hammond, alternate
Eleventh District — Lowell J. Hillis, Logansport
Twelfth District — Milton F. Popp, Fort Wayne
William R. Clark, Fort Wayne, alternate
Thirteenth District — Not represented

Officers:

Kenneth O. Neumann, Lafayette, president
Eugene S. Rifner, Van Buren, president-elect
Ottis N. Olvey, Indianapolis, treasurer
Lester H. Hoyt, Indianapolis, assistant treasurer

Journal:

Frank B. Ramsey, Indianapolis, editor

Executive Committee:

Ralph V. Everly, Indianapolis, chairman
G. O. Larson, LaPorte, member

Guests:

Harold C. Ochsner, Indianapolis, AMA delegate
Guy A. Owsley, Hartford City, AMA delegate
James H. Gosman, Indianapolis, AMA alternate delegate
Robert M. Brown, Marion, AMA alternate delegate
Dwight W. Schuster, Indianapolis, AMA alternate delegate, and chairman, Commission on Legislation
Lester D. Bibler, Indianapolis, AMA trustee, and chairman, Student Loan Committee
Herman Wing, Gary, member, AMA Technical Committee
Donovan F. Ward, Dubuque, Iowa, past-president, AMA
Mr. Frank K. Woolley, Chicago, AMA field representative
Ralph Sappenfield, Indianapolis, alternate AMA delegate, Section on Anesthesia
William B. Lybrook, Indianapolis, president-elect, Marion County Medical Society
Mr. John B. Twyman, Gary, executive director, Lake County Medical Society

Staff:

Ralph Hamill, attorney
Robert J. Amick, field secretary
Howard Grindstaff, field secretary
Kenneth W. Bush, administrative assistant
James A. Waggener, executive secretary

On motion of Drs. Neumann and Popp, minutes of the meeting held January 23, 1966, were approved as printed.

Reports of Councilors

DR. WILHELMUS, First District, extended an invitation to all members of the Council to their district meeting, to be held the last Thursday in May (May 26). Secondly, he spoke of the dissatisfaction of the hospitals in his district with the approval of the Utilization Committee's program from the State Board of Health. (The chairman announced that this subject of utilization would be discussed by Dr. Offutt later in the meeting.)

DR. EDWARDS, Second District, announced that his district society meeting will be held in Washington, Indiana, on June 9, at the local Elks Club. An Academy of General Practice Road Show will constitute the program.

DR. WISEMAN, Fifth District, reported that the Parke-Vermillion County Medical Society will be host for the Fifth District meeting, but no date had been set as yet for this meeting.

DR. TINDALL, Sixth District, reported that the Sixth District will meet at Shelbyville on April 27, with an Academy of General Practice Road Show in the afternoon and dinner with a speaker in the evening.

DR. DONATO, Seventh District, invited the Council to the Seventh District meeting, to be held at Bloomington on June 15. The Owen-Monroe County Medical Society will also be invited to attend this meeting.

DR. TAYLOR, Eighth District, reported that the Eighth District would meet on June 1 at the Delaware Country Club, Muncie, with social events in the afternoon and a

guest speaker at the dinner meeting.

DR. PETRICH, Ninth District, announced the Ninth District Society would meet at Fowler on May 19.

DR. HILLIS, Eleventh District, confirmed the date of September 21 for the Eleventh District meeting, to be held at Kokomo.

DR. POPP, Twelfth District, reported that the Twelfth District would meet at Bluffton on Wednesday, May 18, 1966.

Announcement was made that the Thirteenth District Society meeting will be held at Elkhart on September 14, 1966.

Unfinished Business

1. *Transfer of fees for radiology and pathology services from Blue Cross to Blue Shield.*

a. *Wabash County case.* Judge Hamill reported that he was in Columbia City two weeks ago and had had an oral argument on the motion to make more specific and the motion to strike. He had suggested to the local counsel that inasmuch as certain aspects of the case needed to be more specific, an amended complaint should be filed. To date the local court has not ruled.

Judge Hamill and Mr. Grindstaff also reported that a likelihood of a compromise exists and the lawsuit will be dismissed, in view of the fact that a physician has been appointed to the board of trustees of the hospital and one other member of the board who was opposed to the Wabash County physicians is going to resign and his prospective successor is known to be favorable to the physicians on the hospital staff.

b. *Jackson County mutual working agreement.* The chairman stated that this item was put on the agenda as the association officers felt that the other districts "should know there is activity going on in several localities."

During a discussion by many, it was reported that the pathologists and radiologists who are practicing in the Jackson County Hospital have had an attorney employed for the past six months, have 100% backing of the members of the Jackson County Medical Society, and are determined that the practice of radiology and pathology in the Jackson County Hospital and all those in which they are involved will be the private practice. They have made arrangements to set up a laboratory across the street from the hospital, if they have to go this far. The hospital board has not yet given approval of the mutual working agreement, but the physicians involved are hopeful that approval will be forthcoming prior to the termination of their 90-day contracts with the hospital. They have already given the hospital board notice of the termination of their contracts.

It was also reported that within three weeks, a new contract to everybody's liking, including 80% of the hospital board, probably would be negotiated.

c. *Resolution adopted by Indiana Hospital Association.* The IHA resolution was discussed by Drs. Donato, Gosman, Judge Hamill, Drs. Neumann, Rifner, Hillis, Steen, Tindall, Reid, Hoyt and Mr. Woolley.

Dr. Donato read the following letter, addressed to him, from the executive secretary of the Marion County Medical Society:

> The Board of Directors of the Marion County Medical Society, in its recent meeting and following a discussion of the resolution adopted by the Indiana Hospital Association in regard to hospital-based specialists, voted to advise the Council of the Indiana State Medical Association that it considers the resolution repugnant and an affront to the medical profession.
>
> The board voted, also, to urge the Council to seek to have the resolution rescinded or, failing in that, to take whatever legal action which seems indicated to force its rescission.
>
> This is to advise you of the board's action and to request you to convey it to the Council.

Dr. Gosman called attention to certain "whereases" in the IHA resolution, as follows:

> "WHEREAS the hospitals of Indiana represent the patient and public interest in physician-hospital relations, and
>
> "WHEREAS the practice of the hospital-based physician specialist has been developed because of a need to provide a comprehensiveness of medical services in special areas not common to the typical practice of medicine, and
>
> "WHEREAS the hospitals feel a responsibility to develop other services in the future that can be adequately provided only as a hospital-based specialty,
>
> "THEREFORE BE IT RESOLVED that the Indiana Hospital Association board of directors does hereby endorse the maintenance and perpetuation of existing arrangements between hospitals and their physician specialists."

Drs. Donato and Gosman asked that some action be taken on this matter *now.*

The chairman then called for comments on the *Policy Statement of the Council of the Indiana State Medical Association regarding Government Medical Care Programs.* The secretary pointed out that the paragraph on "reasonable fee" had been added since the October 1965 statement of the House of Delegates on "usual and customary fees" had been approved.

Dr. Taylor suggested that the following paragraph be inserted after the first paragraph on page two of the policy statement:

> "It is imperative that radiologists, pathologists and other hospital-based specialists alter their contractural relationships with their various institutions where necessary to comply with the recommended standards established by their respective specialty organizations. The Council of the Indiana State Medical Association pledges its aid and support to these specialists in their efforts to make the required changes in their present relationships with hospitals in Indiana."

On motion of Dr. Popp, seconded by many, the Council voted approval of this addition to the policy statement.

On motion of Dr. Rifner, seconded by many, the Council accepted as a whole the policy statement, as amended with the addition of the above paragraph.

This statement, as amended and adopted, reads as follows:

POLICY STATEMENT OF THE COUNCIL OF THE INDIANA STATE MEDICAL ASSOCIATION REGARDING GOVERNMENT MEDICAL CARE PROGRAMS

Inasmuch as government has announced that it has assumed under Public Law 89-97 responsibility for financing the medical care of certain segments of the population, the Council of the Indiana State Medical Association has adopted certain policies for the information and guidance of its members.

For emphasis, reference is made to Title XVIII — Health Insurance Benefits for the Aged, and Title XIX — Grants to States for Medical Assistance Programs.

It is recommended and urged that every physician follow these policies in the conduct of his individual practice of medicine.

Policies Recommended for Individual Physicians

Once the physician accepts a person as his patient, regardless of what third party might be involved, the physician's primary and sole obligation, his sole contract and his sole relationship are with the patient.

Any arrangement between government and a citizen whereby the government agrees to pay for the citizen's medical care does not, directly or indirectly, or by inference, involve the physician in a contract with the government.

The physician will continue, even as before, to provide those persons he accepts as patients with the best possible medical care at his command.

The physician is requested and urged to deal directly and only with the patient both in providing medical care and in *billing for just* and *reasonable compensation* for the medical care provided.

It is recommended, inasmuch as the agreement for financial responsibility is between the patient and the government, *that the physician not accept any assignment form.*

It is recommended, in accordance with the principles of medical ethics and the decisions of the Indiana Supreme Court regarding corporate practice of medicine, that each and every member of this association submit to the patient his own bill and receive on his own behalf, compensation for his professional medical services.

It is imperative that radiologists, pathologists and other hospital-based specialists alter their contractural relationships with their various institutions where necessary to comply with the recommended standards established by their respective specialty organizations. The Council of the Indiana State Medical Association pledges its aid and support to these specialists in their efforts to make the required changes in their present relationships with hospitals in Indiana.

It is the official policy of this association that every physician bill and receive for his professional medical services his usual, customary and reasonable fee. "Usual, customary and reasonable fee" is defined as follows:

"*Usual* — The 'usual' fee is that fee usually charged for a given service by an individual physician to his private patient (i.e., his own usual fee).

"*Customary* — A fee is 'customary' when it is within the range of usual fees charged by physicians of similar training and experience, for the same service within the same specific and limited geographical area (socio-economic area of a metropolitan area or socio-economic area of a county)."

"*Reasonable* — A fee is 'reasonable' when it meets the 'usual and customary' criteria or, in the opinion of a duly constituted medical society review committee, is justified under what is considered a complexity of treatment which merits special consideration.

In cases where review or mediation may be requested, it is recommended that a standard mediation or review mechanism of the county medical society be utilized. Further, it is recommended that no special review or mediation committee be appointed solely to handle cases involving Public Law 89-97.

Requirement of Pledges or Statements Objectionable

The propriety of the conduct of members of this association is determined by The Principles of Medical Ethics, to which all members of this association willingly and freely pledge themselves.

For emphasis, reference is made specifically to Section 4 of The Principles of Medical Ethics:

> "Section 4. The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession."

The profession finds objectionable and distasteful any regulation or requirement that a physician sign pledges or produce statements that he will abide by or has abided by the laws in providing his professional services. Such requirement or regulation is, of itself, an act of discrimination against the profession, and is degrading.

Dr. Donato moved that the above letter which he had read constitute a motion. Motion discussed by Drs. Reid, Taylor, Neumann, Hillis, Mr. Woolley, Drs. Bibler, Gosman, Donato, Edwards, Ochsner and Steen. **This motion, directing the Indiana State Medical Association to take such action as is necessary to have the Indiana Hospital Association rescind its resolution regarding hospital-based specialists, or failing that, to take legal action against the Indiana Hospital Association, was seconded by Dr. Steen, put to vote, and carried.**

2. *Dubois County matter.* **By consent it was agreed that the Council will meet at 5:30 p.m., Saturday, June 11, 1966, and the hearing on the Dubois County matter will begin at 7:30 p.m. on that date.**

(The Council will reconvene at 9:00 a.m., Sunday, June 12, 1966, to meet with the delegates and alternate delegates to the American Medical Association.)

Introduction of Guest

Dr. Bibler introduced Dr. Ralph S. Sappenfield, an I.U. graduate, who has been practicing anesthesiology in Miami and recently has returned to Indianapolis to become the head of the Anesthesiology Department of the Methodist Hospital. "Dr. Sappenfield is alternate delegate from the Section on Anesthesiology of the American Medical Association and in the near future he will be a regular delegate and I thought that he should be indoctrinated to the thought and concept of what the boys in Indiana feel."

Reports of Officers

DR. KENNETH O. NEUMANN, president: My skin is getting a little thin too, just like Mr. Woolley's and the AMA Board of Trustees. Since last October I have had on the average of four letters a week from various physicians from throughout the state, and you could put half of them on one side and half of them on the other. They are just diametrically opposed. I think you might be interested in this because we talk about unanimity of opinion and ideas and so forth, and this is what you actually turn up with. For example, I have had repercussions from many areas of the state when we sent our field men out to do this selling of the utilization committees. I have had a fair number of letters regarding the program which is scheduled for tomorrow. I have had complaints regarding the President's Page which I wrote and in which I quoted the medical ethics. Included among this are three radiologists and four pathologists who have objected and have said, "You are not telling us what kind of ethics we are going to practice. We are going to do it as we please, how we want to do it, and when we want to do it."

This is an example: this past week as I came down here, I had a letter and I am going to take the time to read it. I hate to do this, but I will read excerpts from it. This is from a doctor in Newburgh, Indiana. He writes: "I wish to inform you that as an accepted leader of American Medicare that *your* proposed program for peaceful co-existence of Medicare means exactly the same thing as peaceful co-existence between the United States and Communist Russia. I do not like to see my independence thrown away by such leaders." Then I get a letter from his wife who says: "Unfortunately family obligations make it impossible for us to attend your meeting on April 17, but as a physician's wife I am interested in how Medicare will be implemented. I am hoping that its effect on my husband's practice will be negligible, as he does not plan to participate. He is a man of principle, an increasingly rare phenomenon, and I am proud to be his wife. I was shocked by your Medicare count-down. It seems to me that you and your colleagues have surrendered." And then she goes on from there.

Well, I am going to read you my reply. Now, I read this for one reason: most of the letters that I have answered to these people have been on a personal basis, and I've tried to keep it that way. This letter specifically refers to me and my colleagues, which I assume to be you, and so I thought that I ought to include you in this. This is a dreadful situation to be caught in and you can't imagine how difficult it is to equate these opposite sides when one group takes one word you say and interprets it one way, and another group takes the word that you say another way. And, furthermore, the ones who seem to be the most loquacious

about these things are people who, in my experience, have done little or nothing to either fight Medicare or to have participated in any medical activity. So my letter to this group is as follows:

"Your separate letters addressed to me have been forwarded to me by the ISMA office. I sincerely regret that you will be unable to attend the meeting in Indianapolis because you have family obligations; I believe you would find it informative. Many of us, too, have family obligations, but we do take time to attend meetings so that we may be better informed.

"The ISMA officers were directed by the 1965 House of Delegates and by the ISMA Council to use every means possible to inform the membership of the ISMA regarding P. L. 89-97. It is towards this end that the meeting on the 17th of April is directed. Your two individual letters are the only ones that I have received objecting to this meeting, or to my views. I have received other letters and I quote from several:

"(1) 'You and the ISMA have made every effort to prevent Medicare from being effective.' (This being from Lake County).

"(2) 'We are ashamed to have officers in the ISMA *opposing* a law of the land.' (and this came from Marion County);

"and (3) 'Your bull-headed opposition to Medicare has caused incalculable loss to Indiana medicine.' (This came from Marion County);

"and (4) 'Why do you continue to oppose Medicare?' (and I don't know where that came from).

"I shall enjoy using quotations from your letters in my reply to these members and others. Their opinion of me and the ISMA seems to differ substantially from yours. I am sorry that your memory is so short or perhaps you did not have time to read my address as President-elect last year. I would ask that you do so, page 1409 and 1410 of the *ISMA Journal* of 1965. Had you taken time to read this and the President's Page in the *ISMA Journal* each month, I am sure you would be more familiar with my views. For your information I am enclosing a copy of a letter I received recently from an officer of the American College of Radiology. (This, incidentally, was the letter from Doctor Buchanan stating he appreciated the fact that I did write this page on medical ethics.) I hope that in the near future you will take the time to read the President's Pages in the *ISMA Journals* since last November, so that you may be better informed.

"I have searched in vain through ISMA files to learn of any activity in which you have been engaged in behalf of Indiana medicine. Being a member of I-HOPE and AMPAC, I reviewed their membership and did learn that in 1964 you thought so highly of your freedom that you donated all of $25.00 towards I-HOPE in our fight against Medicare and support for a conservative cause.

"I regret that your memory is so short that you do not remember the statement presented at the Special Meeting of the AMA House of Delegates last year by the officers and delegates of ISMA. This statement was sent to each ISMA member — it was a strong statement in opposition to 89-97 and the 'so-called' moderate AMA stand. I do not recall your writing to approve of this stand by your officers and delegates. I am sorry you apparently have not had the time to read and study the ISMA Newsletters.

"I, as well as the officers and Council and staff, would be happy to receive any suggestions or constructive criticism from you. I, personally, would be pleased to know precisely what you have done these past few years in opposition to Medicare in order that I may make a fair appraisal of your efforts in our behalf. I should like to be able to judge you objectively on the basis of facts, rather than in the manner in which you have attempted to judge me and the Indiana State Medical Association.

"Sincerely yours,"

I just wanted to bring this up to indicate some of the problems that you run into as far as this office is concerned . . . I will leave this here for the files of the association.

One problem is rather of more concern than this. This year, more than in any before, we have tried to get district meetings not to conflict, and this year we have more conflicts than ever, plus the fact that the GP meeting occurs in May, the annual meeting of the Wisconsin State Medical Association is in May, and the following week is the Illinois State medical meeting, and the following week is the Ohio State medical meeting. This means that it's going to be impossible for me to get to some of these district meetings. Now this is probably a break for the districts because they won't have to put up with me. This is the reason that I will not be at some of these meetings and I apologize. Some of the officers will try to cover each one of the districts.

I have mentioned this in the Executive Committee today — as I have been going around the state, we get a lot of criticism; I say, write them down, send them down to the state headquarters. They say, "You are our president, you take the message down to them."

A lot of complaints I have had in the last few months have been on *The Journal*, and Dr. Ramsey and I have talked about this, so he knows about them. They have been complaining about the lack of interesting articles and articles being too long and so forth. I think this is something which you men might keep your ears attuned to in your districts and among your friends and let the editor know. These people aren't going to write back to the editor of *The Journal*. They may complain to you and I know they complained to me, but this is about as far as it goes.

The report from *The Journal* as presented to the Executive Committee was a real good report this time; income is up, advertising is up, etc., so it is doing well though apparently nobody hears too much about it.

One other thing I'll mention while I am on my feet right now, rather than bring it up under the Executive Committee. There is a little problem regarding military memberships for some Indiana residents. Now, the problem is this: some of these fellows have had an internship and a residency and then the Army picks them up and sends them here, there and other places, and some of the county societies will not accept these individuals as members. On the other hand, many have an interest in becoming members of the state medical association, or a medical association, and I would like to suggest to the Council that we approve the policy of permitting a local county in our state to give military membership in the state medical association to a physician they know, whether they be in the state or some place else, on a military basis, even though they previously have not been a member. If he has previously been a member, you can do this without any problem, but there was a question about it. This goes back to the second world war — way back when we ancient characters were around. For some reason or other they wouldn't do this and I never knew why. I would like for the Council to take some action on that today. That's all I have right now. Thank you.

THE CHAIRMAN: Thank you. Doctor Rifner, president-elect, has some interesting remarks for you.

DR. EUGENE S. RIFNER, president-elect: I am not so sure they are interesting. I am rather grateful to be out of the limelight and be the president-elect and not receive any such letters. I felt sorry for such a liberal man as Kenneth getting that letter.

Since we last met, Kenneth and I went to the Pick-Congress, Chicago, for the meeting on ethics and we didn't learn too much up there that didn't go along with the saying that I have quoted to you before: P. C. King's — "There is nothing in medical ethics that interfered with good sound business judgment."

We have had Junior-Senior Day, a couple of I-HOPE boards and a few speeches here and there at the request of the president, and some at the request of Jim, on Medicare. I have had one introduction in my own town on Medicare in which they said that the man down on Social Security says, "You mean he's going to go down there and talk for it,"

and this was an explanation, and so I told them that what I meant was, the government employee who received wages to know about this wasn't smart enough to go down and tell them. I had to.

Now, I have had a little bit of wind taken out of my talk because it seemed to me that our society needed policy, and it sounds to me today as if we are going to get some. I thought we needed policy concerning radiologists and pathologists, either get on or get off the boat and not be in this wishy-washy position we had been prior to your action today.

I think it's time we decide something about utilization committees, and I am sure Doctor Popp will have something to say about them and that we take some stand here. I think it is well for you to know that Jim has found out that the HEW says that we should participate in the education of physicians — this really should be done by the carrier, but we should participate in it, but there would be no funds to do this with, that this was just our obligation, and that this was in the law. I think that we need to take a stand and get on or get off so that we can answer some of these questions just a little bit more specifically than by asking, "What have you done?" I think we need to say, "This is the stand of this society."

It seems to me that in the past I have sat there and I have been here, and we have kicked it all around, but no one ever came up with "Yes" or "No." We are going to have to take those stands today so that the officers can speak with a policy action on every question, so that we don't have any problems about where we stand with respect to radiologists. I have heard a lot today and I would like to take this as an aside — the radiologists and pathologists in my area just don't agree with you fellows at all. They like it the way it is, and we would have some problems with this resolution there, I am sure. These are all the comments that I have. Thank you, sir.

DR. OTTIS N. OLVEY, treasurer, gave the following report, as of April 15, 1966:

Cash Report:

General Fund Checking Account	$ 26,606.61
Savings Account	47,801.82
In 30-day Bills	10,000.00
In 60-day Bills	50,000.00
In 181-day Bills	100,000.00
In other securities	60,000.00
TOTAL	$294,408.43

Obligations:

Student Loan dues, 1965-1966, to date	$ 38,165.00
AMA-ERF dues, 1966	18,870.00
Reserves and obligations	60,877.14
TOTAL	$117,912.14

Summary of all Funds:

General Fund, Cash and Investments	$294,408.43
Journal funds, cash	8,025.05
Medical Defense Fund, cash and investments	38,617.93
Building Fund, cash	6,585.30
Student Loan Fund, cash and investments	27,163.04
Kitchen Fund	1,696.44
TOTAL	$376,496.19

On motion of Drs. Popp and Steen the above report was accepted and the Council commended the treasurer on the excellency of his report.

DR. FRANK B. RAMSEY, editor of *The Journal:* I want to emphasize what Dr. Neumann said about suggestions or comments about *The Journal.* Usually the Editorial Board and the editors and I feel we don't get enough suggestions. Our obligation, of course, is to publish in *The Journal* what most of the people want. We know it is impossible to have everybody like everything in *The Journal*, but we try to hit a happy medium. I think if you will all do as Dr. Neumann does, and ask them to write me a letter about *The Journal*, or if they are inclined not to write, let me know or let one of the editors know, we will try to please as many of the members as possible.

The financial report at the end of the first six months of the fiscal year is good. We have taken in more revenue than we anticipated. In fact, we are six percent ahead on revenue. We have spent less; we are eight percent less on the printing bill than we expected to be.

There is one other thing that I need to tell you about. It's a paradox. As you know, I am president of the State Medical Journal Advertising Bureau which handles the national advertising for 32 journals, including this one. Since the first of the year, the bureau is 40% up from the same period last year, and Indiana, in common with several other journals, has the distinction of being a problem child with the national bureau since we are only up 24%. Some of the journals have gained 100% in advertising revenue since January 1 as compared with 1965, and many of them are above 70 and 80%. So the 24% doesn't seem like very much.

Now, as a matter of fact the financial part of it isn't so important to us. We operated last year on a fairly good sized journal and came out some five to six thousand dollars ahead of even, and we can do that for a long time. However, we look forward to the time when we would like to have a bigger journal and a little more time to get interesting features in it, and we also look forward to the time when expenses are bound to be greater, so this 24% isn't satisfying at all. And strictly aside from that, and as a matter of prestige, since I am president of the advertising bureau, I would like to see Indiana doing a little better.

Most of the journals that are doing real well with their advertising now are from the southern part of the United States. For some reason, advertising in those journals produces more reaction from the doctors than it does from the same advertisement that is placed in a northern journal. I might say that the pharmaceutical people have ways of very accurately measuring the effects of all their promotional work; they know exactly how many prescriptions are written as a result of their advertisements, how many as a result of their detailing efforts and other promotional activities in the same way.

In May, Indiana is one of the twelve states that will carry a two-page insert of a company which has not advertised with us before. It's Cooper, Tinsley Laboratories, which has a desire to promote one of their products each month for a while. They have 20 products and they tell us they will continue to promote those products one at a time as long as they find that it is advantageous for them to do so. The other is a four-page insert by Dorsey Laboratories, which is a new departure in pharmaceutical advertising. It is the type of advertisement that has a "soft sell" arranged around an editorial discussion of the problem for which the drug is designed. In May, the editorial matter is written by a senior member of the Mayo Clinic — he is so senior he didn't allow them to use his name. Dorsey plans to repeat this on a seasonal basis, at least four times a year, in all of our journals, four pages in all. I would like to ask each of the councilors and each of the officers, if you would promote amongst anyone you see, a desire to write a letter to Dorsey Laboratories — the medical director is an M.D. and his name appears in the ad. Just make an appreciative comment on the advertising, its usefulness and the beauty of its layout.

In the case of Cooper, Tinsley, we expect to write a letter or send a flyer to every member of the association and ask them to complete a coupon which appears in their advertisement. These are things which I feel probably do advertising more good in the southern part of the country, and if the northern journals can adopt these procedures, there is no reason why we shouldn't have some of this 100% increase in our advertising.

DELEGATES TO THE AMA: Dr. Shields expressed the hope that the AMA delegates would be supplied with some good resolutions to be presented to the AMA House of Delegates at the June meeting in Chicago. He suggested that a resolution on communications media be prepared for introduction.

The preparation of resolutions in advance of the Chicago meeting was seconded by Dr. Owsley who said, "A number of controversial subjects need to be aired and if we had more resolutions to present, it would make Indiana look a little bit better."

Dr. Owsley commented that a resolution regarding the News Letter had been introduced previously at the AMA by the Indiana delegates and it was reported "do not pass" out of the reference committee with the argument that the expense would be prohibitive and the same information could be carried in the *AMA News*.

Drs. Ochsner, Owsley and Sappenfield discussed the possibility of Indiana supporting the candidacy of Dr. Edward Annis for membership on the AMA Board of Trustees.

On motion of Drs. Taylor and Wilhelmus, the Council voted to support any action that the delegates to the AMA may take in furthering Dr. Annis' candidacy for membership on the AMA Board of Trustees.

The proposed increase in AMA membership dues was discussed by Dr. Ochsner, who reported that he had attended several county medical society meetings at which the increase had been accepted without objection; by Dr. Owsley, who said he had had favorable letters from Vigo and Vanderburgh counties, and in his own society the vote was 19 against, 4 for, and 27 abstaining, and by Dr. Shields who reported that he had received a letter from the Floyd County Medical Society protesting the increase.

Matters Referred to Council by Executive Committee

In the absence of Dr. Everly, chairman of the Executive Committee, Dr. Neumann presented the following matters:

1. *Student Loan Fund.* Dr. Neumann and the secretary explained that the $40,000.00 originally allocated to the Student Loan Fund by action of the House of Delegates, will guarantee $500,000.00 worth of loans to medical students. Total loans after three years of operation under the new plan with the Indiana National Bank, amount to $47,000.00. The Guaranteed Student Loan Fund, derived from the $5.00 or 50% of the $10.00 dues structure for medical education, now amounts to approximately $56,000.00. Inasmuch as the original $40,000.00 will eventually revert to the Student Loan Fund, it is the recommendation of the Student Loan Committee that the guaranteed loan fund of $56,000.00 be re-allocated and transferred to the general fund until such time as on annual review by the Executive Committee in conjunction with the Student Loan Committee, such fund or some part thereof may be needed for the purpose of guaranteeing loans under the agreement with The Indiana National Bank.

Dr. Neumann read the resolutions which had been adopted by the Student Loan Committee and the Executive Committee. **The following resolution was then presented and on motion of Drs. Neumann and Petrich, it was adopted by the Council:**

RESOLUTION OF COUNCIL

The Executive Committee reported to the Council its action and the action of the Student Loan Committee in reference to the allocation of the fund created and accumulated pursuant to the resolution of the House in 1963 by which fifty (50%) percent of the $10.00 in the dues structure for medical education was allocated as a fund to guarantee loans made by The Indiana National Bank to medical students.

After the Council considered the report, findings, and recommendations of the Student Loan Committee and of the Executive Committee, and the written opinion of legal counsel, and the resolutions of the Executive Committee made in conjunction with the Student Loan Committee, after discussion, the following resolutions were moved, seconded, and carried:

1. That all of said fund resulting from the dues structure pursuant to the resolution of the House in October, 1963, and which have not already been deposited with The Indiana National Bank as a pledge to guarantee such loans, be no longer allocated for the purpose of guaranteeing such loans to medical students under the arrangements heretofore made with The Indiana National Bank and that they be re-allocated and transferred to the general fund until such time as on annual review by the Executive Committee in conjunction with the Student Loan Committee such fund or some part thereof may be needed for the purpose of guaranteeing loans under the agreement with The Indiana National Bank.

2. That such part of said fund as has heretofore been invested in certificates of deposit in The Indiana National Bank and used as a "capital reserve" to guarantee loans to medical students under paragraph 9 of said agreement with said bank be withdrawn from said "capital reserve" or guarantee fund, subject to the approval of said bank, and that an equal amount of certificates of deposit be purchased with funds on hand as a part of the trust fund of approximately $40,000.00 and be delivered to said bank as a "capital reserve" in lieu of those withdrawn. That after the said withdrawal of said certificates of deposit they be no longer allocated to said guarantee loan fund, but be re-allocated and transferred to the general fund until such time as on annual review by the Executive Committee in conjunction with the Student Loan Committee such fund or some part thereof may be needed to be used for the purpose of guaranteeing loans under the agreement with The Indiana National Bank.

2. *Military memberships.* **Dr. Neumann moved that the Council establish a policy that it is permissible for a local county medical society to grant to an Indiana physician a military membership even though he may not be currently practicing within his own county. Motion seconded by Dr. Wilhelmus, put to vote, and carried.**

3. *Matters Referred to Executive Committee by Commission on Public Health:*

a. "*The Principles of Industrial Practice in Indiana.*" Dr. Neumann reported that the Commission on Public Health had passed a motion that 7,000 copies of this booklet be printed and that a direct mailing be made to the membership and that copies be distributed to the medical schools and to interns. The Executive Committee had considered this request, and the committee recommended that a notice be sent out in the *News Flash*, or be published in *The Journal*, that reprints of this publication are available in the headquarters office and anyone wishing a copy may obtain a Xeroxed copy on request. These Principles were printed in the September, 1965, *Journal* as a part of the annual report of the Commission on Public Health.

On motion of Drs. Neumann and Rifner, the Council concurred in the Executive Committee's recommendation that when requests are received for "The Principles of Industrial Practice in Indiana" Xerox copies shall be made and sent out rather than having this material printed.

b. *Material on Social Security Disability.* Dr. Neumann reported that the Commission on Public Health had had much discussion at various times with the Social Security Administration regarding printing and distributing to all Indiana physicians, at no expense to the association, the Social Security Administration's brochure entitled, "Facts on Social Security Disability for Indiana Physicians." The motion passed by the Commission on Public Health, at its meeting on February 10, 1966, is as follows:

"Doctor Painter moved that the attached material on Social Security Disability be submitted to the Council in order that it can be published and distributed by the state society, at no expense to the society, to all doctors in Indiana. He further moved that a cover identifying the material with the Indiana State Medical Association be approved and a note be added that the material was prepared for the state association by the Social Security Disability Determination Unit for the State of Indiana. It is intended to ask the state society to print eight to ten thousand copies of this and that the state

society undertake the initial mailing to all doctors in Indiana and turn the balance of the copies over to the Disability Determination Unit. *In case there is any misunderstanding, the entire cost of this project, both in printing and in distributing, is guaranteed by the Social Security Administration.* Doctor Williams seconded the motion, motion carried."

Dr. Neumann said that (1) the Executive Committee had no written document that the Social Security Administration would do this; (2) the committee felt that most of this material would be tossed into the wastebasket; (3) the printing cost would be excessive, and (4) the committee was not too happy about the appendage on the cover page, "Approved for Issuance by the Indiana State Medical Association."

The Executive Committee recommended that Xerox copies be utilized in filling requests for this material and that this extensive printing and mailing not be done.

Dr. Hillis said this item, together with an item of the meeting of the Commission on Aging, held on Sunday, February 20, 1966, was discussed at the Cass County Medical Society meeting and with physicians in Cass county, and, as previously instructed, he read to the Council a letter concerning these matters which he had received from Drs. Camille Parker and Francis Parker.

On motion of Drs. Neumann and Popp, the Council concurred in the recommendation of the Executive Committee that requests for this material be filled with Xerox copies and the members of the association are to be informed that this information on Social Security Disability is available through the ISMA headquarters office on request.

Economic and Organization Matters

1. *Remission of state dues was approved by the Council for the following members, on motion of Dr. Steen, seconded by many:*

Vanderburgh County — One member — ill health

Marion County — Three members; two because of illness, and one because of retirement

Lake County — One member — retirement

DeKalb County — One member — illness

Wells County — One member — retirement

Elkhart County — One member — serving in overseas religious service

2. *Nominations of two members for Editorial Board* for three-year term ending December 31, 1969, to succeed Drs. George M. Johnson, Richmond (surgery), and Irvin W. Wilkens, Indianapolis (internal medicine), whose terms expire December 31, 1966, were deferred until the July Council meeting.

3. *Blue Shield Board of Directors.* It was called to the attention of the Council that Districts 4, 7, 10 and 13 should nominate this year one member each for the Blue Shield Board of Directors, for the three-year term beginning March, 1967, and ending March, 1970.

Blue Shield Board members-at-large. The terms of the following Board members-at-large will expire March, 1967:

John W. Beeler, Indianapolis (radiology), and William E. Bayley, Lafayette (pathology).

On motion of Drs. Taylor and Donato, Dr. Beeler was nominated to succeed himself for the three-year term from March, 1967, to March, 1970.

On motion of Drs. Petrich and Wiseman, Dr. Bayley was nominated to succeed himself for the three-year term from March, 1967, to March, 1970.

New Business

1. *Hospital-based specialists.* **Dr. Steen presented the following resolution and moved its adoption. Motion seconded by Dr. Neumann.**

> WHEREAS, the Indiana State Medical Association has long and persistently urged the fiscal separation of hospital-based specialists from their hospital base, and
>
> WHEREAS, the specialty societies of these hospital-based specialists have repeatedly urged their membership to divorce themselves from hospital employ, and
>
> WHEREAS, the Medicare law makes explicit its intent as to the relationship of hospital-based specialist and the hospital,
>
> NOW THEREFORE BE IT RESOLVED that the Council of the Indiana State Medical Association declares participation in remuneration on other than a fee for service basis an unethical act.

Discussed by Drs. Steen, Popp, Wing, Reid, Clark, Hoyt, Wilhelmus and Judge Hamill, following which **Dr. Steen moved "that the matter be tabled in view of the suggestions of our legal counsel but that the resolution be printed in its entirety in the minutes in The Journal." Dr. Petrich also moved "in view of the comments of Judge Hamill that the matter be tabled." The motion to table the resolution was passed on a roll call vote, 9 to 5, as follows:**

First District — Wilhelmus — to table
Second District —
Third District — Wallace — to table
Fourth District — Reid — not to table
Fifth District — Wiseman — not to table
Sixth District — Tindall — to table
Seventh District — Donato — to table
Eighth District — Taylor — to table
Ninth District — Petrich — to table
Tenth District — Steen — to table
Eleventh District — Hillis — not to table
Twelfth District — Popp — to table
Thirteenth District — not represented
President — Neumann — not to table
President-elect — Rifner — not to table
Treasurer — Olvey — to table

Following further discussion, a motion by Dr. Wilhelmus that Judge Hamill research this problem and report back in ten days with a solution in the form of a resolution and then that a telephone conference be held to secure a vote was lost for want of a second.

On motion of Dr. Steen, taken by consent, the Council recessed for ten minutes for caucusing.

2. *Candidacy of Dr. Guy A. Owsley for membership on Council on Medical Service of the AMA.* **On motion of Drs. Neumann and Petrich, the Council voted to formally instruct the delegates and alternate delegates to the AMA and anybody else so involved that Dr. Owsley should be supported with vigor and that the officers and delegates should do everything in their power to secure his election.**

Matters from Committees and Commissions

1. *Council Liaison Committee with Blue Cross.* Dr. Taylor, Blue Cross Liaison representative, presented the following report:

At the annual meeting of Blue Cross on March 24, 1966, Drs. Stangle, Neumann, Rifner, Hoyt and Megenhardt were reelected to the board of directors of the organization. The annual report indicated that Blue Cross enjoyed another successful year in terms of service and financial growth.

Blue Cross has announced and is actively promoting a policy, with various options, to the over-65 age group to supplement Medicare benefits to this segment of the population. In so doing, it will discontinue its present policies offered to the over-65 age group as of 1 July, 1966. This will, in effect, deny certain individuals desired health insurance coverage, where they do not want to participate in Medicare. I believe this is a breach of faith by Blue Cross with individuals in this category and this action should be protested by the Indiana State Medical Association.

In addition, your liaison member continues to be alarmed by the activity of the rate committee of Blue Cross. Upon our recommendation, Dr. Stangle has been appointed a member of this committee; how-

ever, he has a minority voice and probably will not be able to effectively alter this committee's findings.

I feel especially concerned about this committee's action in approving or disapproving changes in fee schedules for radiology and pathology services in hospitals. These are professional charges and should not be in any manner subject to scrutiny by Blue Cross.

Respectfully submitted,
Donald R. Taylor, M.D.

Dr. Taylor's motion for acceptance of his report was seconded by Dr. Petrich, put to vote and carried.

The secretary reported that he had received innumerable calls and letters from physicians complaining about the fact that Blue Cross and Blue Shield both have been canceling out people over 65, and that he had inquired of Blue Shield as to what was going to be done about the coverage of the physicians' group through the state medical association. According to a letter received from an over-65 member of the association, his coverage will be terminated as of June 30, 1966. The secretary said it was his impression that the Council had the sole authority to negotiate with the Blue Shield, particularly concerning coverage of physicians in the Indiana State Medical group. "Now, it appeared to me from the criticism I am receiving that the insurance industry, including the Blues, has driven people into the federal program by its actions, and I think if this is true, and if this is the feeling of the Council, the Council should voice a very strong protest on it."

The chairman said the reason the insurance industry has taken this attitude is to avoid duplication of benefits because practically all persons over 65 are eligible in the government program, and physicians in general have complained about getting more than 100% return on costs through an insurance program.

On motion of Drs. Rifner and Popp, the Council voted to protest strongly the action of Blue Cross, Blue Shield and any other insurance companies writing non-cancelable policies in terminating these policies without the consent of the policyholders. Included in this motion was the suggestion of the chairman that this protest should be sent to the Health Insurance Council.

2. *Utilization Committees.* The problem of utilization committees as related to Medicare was discussed by many, including the two field men who had been sent out on instructions of the Executive Committee as an interim crash program, to disseminate information on this matter to the physicians in their respective districts, and in line with the Council's previous action that all information possible on this program should be presented to the county medical societies.

The chairman asked if the Council had any particular action it wished to recommend.

Drs. Rifner and Neumann asked that the Council take some action in order that as they travel about the state they might be able to inform the various county societies just what the state association recommends.

The chairman mentioned that the AMA and ISMA had taken the viewpoint on the broader question of participation and had said, "It's the individual physician's decision, and similarly, this would be an individual county society decision."

The field men commented that 95% of the counties say they are going to have utilization committees. "The 95% who think they are going to do it think that they don't have any other choice, that it's going to be done one way or the other, so why not do it themselves?"

It was the consensus of many that the state medical association should establish some definite policy. "Are we going to function in our local areas as utilization committees under the new law, Medicare, July 1, 1966, or are we going to slough this off under the third option to HEW, on a unified basis throughout the state? That is what Dr. Rifner and Dr. Neumann have to know when they go out and talk to people."

Dr. Hillis called attention to the last paragraph on page 2 of the policy statement which the Council had already approved, and the chairman explained that in this context it is ordinarily considered fee review.

Dr. Popp discussed the report adopted by the Allen County Utilization Committee Study Committee, in which Allen County (1) took the third option for establishment of utilization committees in various hospitals, in which a committee not including local physicians be established; (2) will not provide utilization committees for extended care units; and (3) adopted a resolution directed to hospital staffs to have added to hospital admission forms a statement to be signed by recipients under Medicare.

3. *Steen resolution on hospital-based specialists.* The chairman called for a report from the special committee on the Steen resolution. Dr. Steen asked for suspension of the rules in order that this matter might be discussed.

Dr. Steen reported that he and the committee "had attempted to write a 'resolve' that would be acceptable to the legal counsel in such a manner as to not involve us in further litigation after the thing has been passed," but they had been unable to do this and he therefore recommended that the Council meet at a later date to consider this matter. In the meantime Judge Hamill is to come up with an appropriate resolution.

Dr. Steen was asked to read the new "resolve" that he and his committee had written, which follows:

> "NOW THEREFORE BE IT RESOLVED that the Council declares it imperative that all members shall comply with the provisions of the Medicare law insofar as it pertains to physicians billing for professional services rather than the hospitals usurping this function."

Judge Hamill suggested that "usurping this function" be omitted and that the resolve be ended with "hospitals."

4. *Taylor amendment to Policy Statement of the Council of ISMA regarding Government Medical Care Programs.* Following discussion by Drs. Steen, Taylor, Rifner, Donato, Neumann, Edwards, and Judge Hamill, **upon motion of Drs. Popp and Olvey, the amendment proposed by Dr. Taylor and adopted by the Council earlier in the meeting and inserted in the policy statement of the Council regarding government medical care programs was rescinded on a roll call vote, 8 to 4.** This paragraph is as follows:

It is imperative that radiologists, pathologists and other hospital-based specialists alter their contractural relationships with their various institutions where necessary to comply with the recommended standards established by their respective specialty organizations. The Council of the Indiana State Medical Society pledges its aid and support to these specialists in their efforts to make the required changes in their present relationships with hospitals in Indiana.

4. *Council Liaison Committee with Blue Shield.* Dr. Steen reported that at the meeting of the Council Liaison Committee with the Blue Shield Board on January 30, 1966, the following matters were discussed:

(1) Contract developed by Community Hospital of Indianapolis for coverage of emergency room with four practicing physicians, seven days a week, 24 hours a day. The board agreed to continue to indemnify these physicians as private practicing physicians.

(2) Blue Cross-Blue Shield Medicare Supplement Plan was changed to avoid over hospital utilization which would have occurred as a result of the $50.00 deductible clause (paragraph 6). This same paragraph 6 provides for Blue Cross to continue payment for professional services, namely, x-ray, laboratory and diagnostic services. "Dr. Beeler questioned the continuation of inclusion of these services under the Blue Cross portion. He was informed that the board was only considering the Blue Shield portion of this coverage. However, this plan is a joint plan of Blue Cross and Blue Shield and in view

of the many resolutions which have been adopted by the Indiana State Medical Association requesting the removal of professional services from Blue Cross to Blue Shield, the board did, in fact, inasmuch as this is a joint plan, give approval to the inclusion of professional services in the Blue Cross portion of the contract. This would seem to many to further stall or be a hurdle in our effort as a medical association to accomplish this transfer."

(3) The board voted to defer any further action on the income deferment plan that had been discussed previously.

The liaison committee suggested that the chairman of the Council be permitted to appoint one member of this liaison committee as chairman, to avoid lapses in attendance such as occurred during 1965. The chairman of the Council then appointed Dr. Steen chairman of the Council Liaison Committee with Blue Shield.

5. *Steen resolution.* Discussion of the Steen resolution was resumed. **Dr. Donato moved, seconded by Dr. Popp, that each councilor mail his approval or disapproval into headquarters office, after Judge Hamill gets the proper resolution.** This motion was not put to vote.

Dr. Wilhelmus suggested that the resolution to be written by Judge Hamill be sent to Council members by mail, and then the secretary call each councilor and secure his approval or disapproval. Discussed further by Drs. Steen, Taylor, Judge Hamill, Dr. Donato and the secretary.

The chairman suggested that "if everybody agreed that if the judge can come up with something that is written down, to express the feeling of this Council, and if it is mailed to each of us and we should mail back an answer and we could vote that way, that the Council adjourn and reconvene in order that this matter could be removed from the table."

On motion of Drs. Donato and Popp, the Council voted to reconsider this matter, and when the legal counsel submits a properly stated resolution, it is to be mailed to the members of the Council eligible to vote and each member is to send in a written vote in reply, at the earliest time possible, and at the outside, within two weeks.

Dr. Lester D. Bibler, AMA Trustee, reported on activities of the AMA Board of Trustees.

Dr. Bibler introduced Dr. Donovan F. Ward, of DuBuque, Iowa, immediate past-president of the American Medical Association, who spoke briefly on the Medicare law.

By consent, July 17, 1966, was set for the next meeting of the Council.

There being no further business, the meeting was adjourned. ◄

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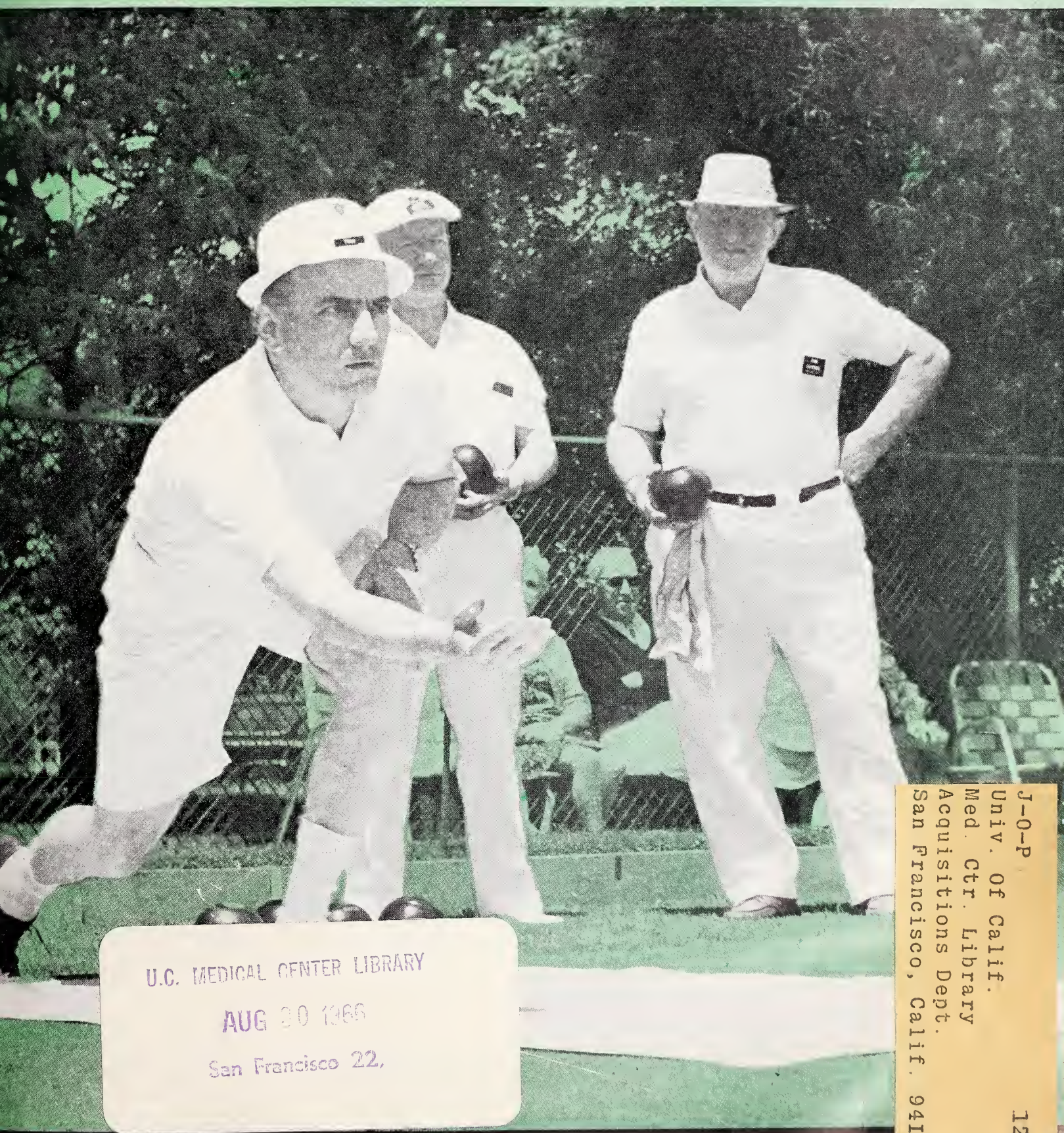

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Reese, H. H.: *Wisconsin*

M. J. 15:344, 1939.
higan M. Soc. 38:317,

oran, T. H.: *Ann. Int.*

utnam, T. J.: *Arch. Neu-*
053, 1939.
l Sc. 85:986, 1939.
l, D. L., Jr., and Arnold,
nth. 66:522, 1939.

Osgood, R.: *J.A.M.A.*

nnett, C. L.: *Psychiat.*
.
Washington Bull. 3:16.

ldstein, H. H.: *Am. J.*
1940.
son, V.: *Ann. Int. Med.*

M.A.J. 43:157, 1940.

ulane Med. Fac. 1:2,

Times 69:461, 1941.
Shallenberger, D. W.:
383, 1941.
Bull. Veterans Admin.

et 61:178, 1941.

Rec. 155:105, 1942.
J. Psychiat. 98:515,

A. 120:449, 1942.
J. Psychiat. 99:231,

70:244, 1942.
renner, C.: *J. Nerv. &*
942.
rieff, A. J.: *J.A.M.A.*

Queries & Minor Notes: *J.A.M.A.* 124:200, 1944.
Gingrass, R. P.: *Wisconsin M. J.* 43:934, 1944.
Vallotton, C. F.: *Virginia M. Month.* 71:159, 1944.

Butter, A. J. M.: *J. Neurol. Neurosurg. & Psychiat.* 8:49, 1945.
Lennox, W. G.: *M. Clin. North America* 29:1114, 1945.

Bashinsky, B.: *J.M.A. Georgia* 35:228, 1946.

Twitchell-Allen, D.: *Arch. Neurol. & Psychiat.* 57:617, 1947.
Keith, H. M.: *Am. J. Dis. Child.* 74:140, 1947.
Wigton, H. A.: *Nebraska M. J.* 32:272, 1947.
Hoefer, P. F. A.; Hoff, H. H., and Pluvinage, R. I. L.: *Tr. Am. Neurol. A.* 72:185, 1947.

Fabing, H. D., and Hawkins, J. R.: *Ohio M. J.* 44:257, 1948.
Thorne, F. C.: *Am. J. Psychiat.* 104:570, 1948.
DeJong, R. N.: *Am. Practitioner* 3:233, 1948.
Tudor, R. B.: *J. Lancet* 68:391, 1948.

Yannet, H.; Deamer, W. C.,and Barba, P. S.: *Pediatrics* 4:677, 1949.
Silverstein, A.: *Am. Practitioner* 3:344, 1949.
Lennox, M. A.: *Am. J. Dis. Child.* 78:868, 1949.

Roseman, E.: *Postgrad. Med.* 8:419, 1950.
Ruskin, D. B.: *Am. J. Psychiat.* 107:415, 1950.
Chaiken, B. H.; Goldberg, B. I., and Segal, J. P.: *New England J. Med.* 242:897, 1950.

Forster, F. M.: *J.A.M.A.* 145:211, 1951.
Bakwin, R. M., and Bakwin, H.: *J. Pediat.* 39:776, 1951.
Ransone, J. T.: *Virginia M. Month.* 78:303,

Sokolova, E. I.: *Zhur. nevropat. i psikhiat.* 53:385, 1953.

Davidson, D. T., Jr., and Lombroso, C.: *New England J. Med.* 251:853, 897, 1954.
Hopkins, S. J.: *Chemist & Druggist* 161:628, 1954.
Hernandez, R., L.: *J. Am. M. Women's A.* 9:188, 1954.

Drew, A. L.: *Postgrad. Med.* 18:327, 1955.
Williams, E. Y., and Carmichael, C. P.: *J. Nat. M. A.* 47:162, 1955.
Millichap, J. G.; Lombroso, C. P., and Lennox, W. G.: *Pediatrics* 15:705, 1955.

Murphy, J. T., and Schwab, R. S.: *J.A.M.A.* 160:385, 1956.
Livingston, S.: *Postgrad. Med.* 20:584, 1956.
Gruber, C. M., Jr.; Mosier, J. M.; Grant, P., and Glen, R.: *Neurology* 6:640, 1956.
Levy, L., and Shanbrom, E.: *Arch. Int. Med.* 97:599, 1956.
Utterback, R. A.: *Am. Pract. & Digest Treat.* 7:763, 1956.
Zimmerman, F. T.: *New York J. Med.* 56:2537, 1956.

Berry, R. G., in Spiegel, E. A. (ed.): Progress in Neurology and Psychiatry, New York, Grune & Stratton, 1957, vol. 12, pp. 199-211.
Daly, D. D.: *Proc. Staff Meet. Mayo Clin.* 32:257, 1957.
French, E. G.: *Am. J. Psychiat.* 113:629, 1957.
Maltby, G. L.: *J. Maine M. A.* 48:257, 1957.

Rupp, C., Jr.: *J.A.M.A.* 166:1967, 1958.
Peterman, M. G.: *Minnesota Med.* 41:196, 1958.
Livingston, S.: *J. Lancet* 78:182, 1958.
Carter, C. H.: *Arch. Neurol. & Psychiat.* 79:136, 1958.
Keith, H. M.: *J. Lancet* 78:461, 1958.

Yahr, M. D., and Merritt, H. H.: *In Neurol.* 1:76, 1959.
Thomas, M. H.: *J.A.M.A.* 169:457
Peterman, M. G., and Thomas, E.
Times 87:1044, 1959.
Bray, P. F.: *Pediatrics* 23:151, 1
Mulder, D. W.; Daly, D. D.; Rusht
and Yoss, R. E.: *Postgrad. Med.* 2
1959.
Forster, F. M.: *Wisconsin M. J.* 58
1959.
Robertson, E. G.: *Postgrad. Med.*
1959.

Schwade, E. D.: *Geriatrics* 15:11
Schade, G. H., and Gofman, H.:
25:151, 1960.
Forster, F. M.: *Postgrad. Med.* 27
1960.
Livingston, S.: *J.A.M.A.* 174:135,
Friedlander, W. J.: *Am. J. Psychi*
1960.

Kane, C. A.: *Boston Med. Quart.*
1961.
Holowach, J.; Renda, Y. A., and
J. Pediat. 59:339, 1961.
Baker, A. B.: *J. Lancet* 81:235, 1
Roseman, E.: *Neurology* 11:912,

Gruber, C. M., Jr.; Brock, J. T., a
M.: *Clin. Pharmacol. & Therap.* 3
Walker, A. E.: *World Neurol.* 3:18

Pauli, L. L.: *Maryland M. J.* 12:49
Livingston, S.: *Clin. Pediat.* 2:23
Forster, F. M.: *M. Clin. North Am*
47:1579, 1963.
Scholl, M. L.: *New England J. Me*
269:1304, 1963.

Kutt, H.; Winters, W.; Kokenge,
McDowell, F.: *Arch. Neurol.* 11:6
Currier, R. D.: *GP* 30:125, 1964.
Chao, D.; Sexton, J. A., and Davis

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References: (1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

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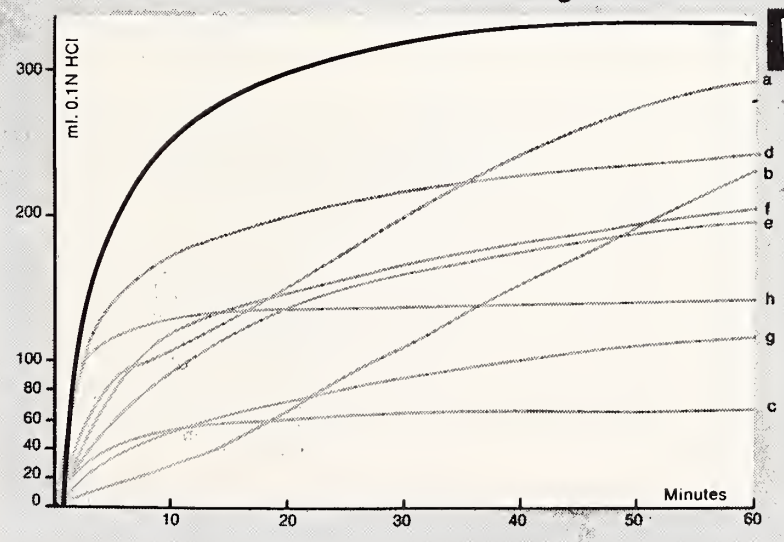

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2—Philip T. Holland, Bloomington	1968
3—Elmer L. Wallace, New Albany	1968
4—Jack E. Shields, Brownstown	1967
5—A. W. Cavins, Terre Haute	1966
6—Frank Green, Rushville	1966
7—Charles A. Jones, Franklin	Spring, 1966
8—Paul Sparks, Winchester	1966
9—Clarence G. Kern, Lebanon	Fall, 1968
10—Lee Trachtenberg, Hammond	Fall, 1966
11—	
12—William Clark, Fort Wayne	Spring, 1968
13—Robert L. Rouen, Elkhart	1967

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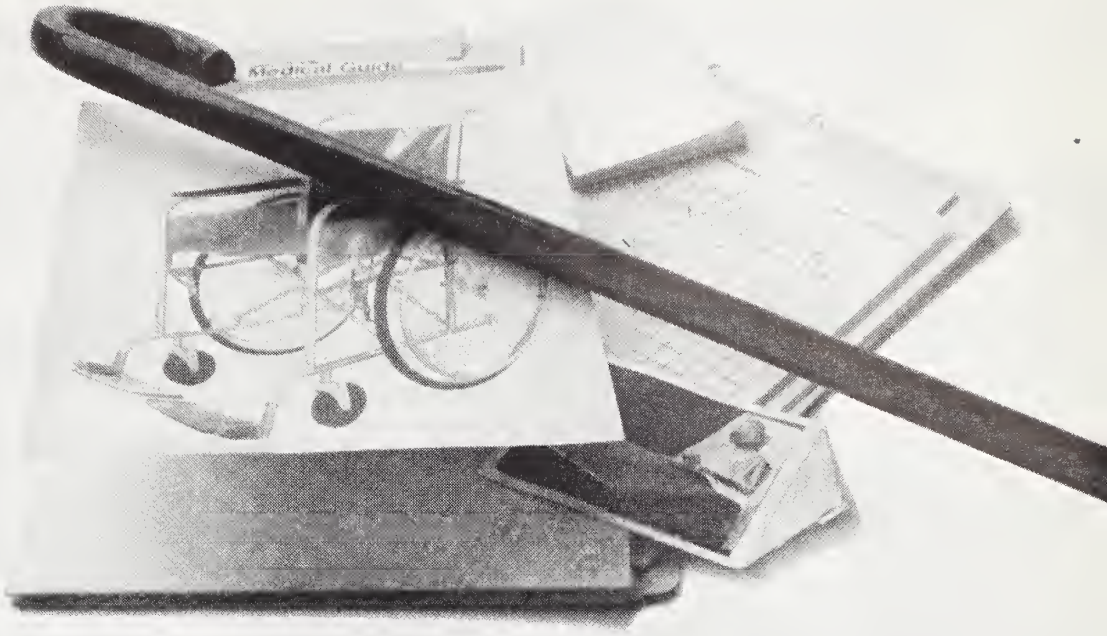
Terms expire **December 31, 1966:**

Delegates	Alternates
Harold C. Ochsner, Indianapolis	James H. Gosman, Indianapolis
	Robert M. Brown, Marion
E. S. Jones, Hammond	Frank H. Green, Rushville

Terms expire **December 31, 1967:**

Delegates	Alternates
Guy A. Owsley, Hartford City	Maurice E. Glock, Fort Wayne
Jack E. Shields, Brownstown	Dwight W. Schuster, Indianapolis



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Vitamin B_6 (Pyridoxine HCl)	2 mg
Vitamin B_{12} Crystalline	4 mcgm
Vitamin C (Ascorbic Acid)	300 mg
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2.	C. Philip Fox, Washington	J. S. Brown, Carlisle	
3.	Daniel H. Cannon, New Albany	Elmer L. Wallace, New Albany	May 17, 1967
4.	Harold W. Richmond, Columbus	David L. Adler, Columbus	
5.	John Ellett, Jr., Coatesville	Richard Veach, Bainbridge	Greencastle, May 17, 1967
6.	J. J. Farrell, Jr., Greenfield	Stephen D. Smith, Knightstown	Columbus
7.	Jay Reese, Martinsville	James H. Gosman, Indianapolis	
8.	Donald E. Spahr, Portland	Joseph F. Vormohr, Portland	Portland, June 7, 1967
9.	Harry T. Stout, Frankfort	Earl K. Williams, Frankfort	May 18, 1967
10.	Leslie Bombar, Munster	Louis Kudele, Whiting	
11.	Reeve B. Peare, Huntington	Carl Ray, Warren	Kokomo, Sept. 21, 1966
12.	Warren L. Niccum, Columbia City	Kenneth F. Isenogle, Fort Wayne	Fort Wayne, May 18, 1967
13.	James W. Hurley, Elkhart	Cecil R. Burket, Bremen	Elkhart, Sept. 14, 1966

The population explosion

Chomp. Chomp. Chomp. He's off again on another spree of second helpings.

Tomorrow, crash! He'll be on a new-fangled diet. Starving himself.

He's just one of the many who bounce between starvation and overeating, and with every rebound make losing weight more difficult.

As a professional, you can help. First by pointing out that skipping meals is no solution, and second by recommending long-range weight control through sensible eating habits and nourishing foods. Every day. Day after day.

Naturally, balanced diets and nourishing, palatable dairy foods go together; they always have.

Project Weight Watch has been initiated to assist you. Its scope is nationwide, its purpose is to focus professional attention on the problem.

To help you translate your concern to your patients, a portfolio of materials is available. Send for it. Support girth control.

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Send requests to 50 S. Parker
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PROJECT WEIGHT WATCH

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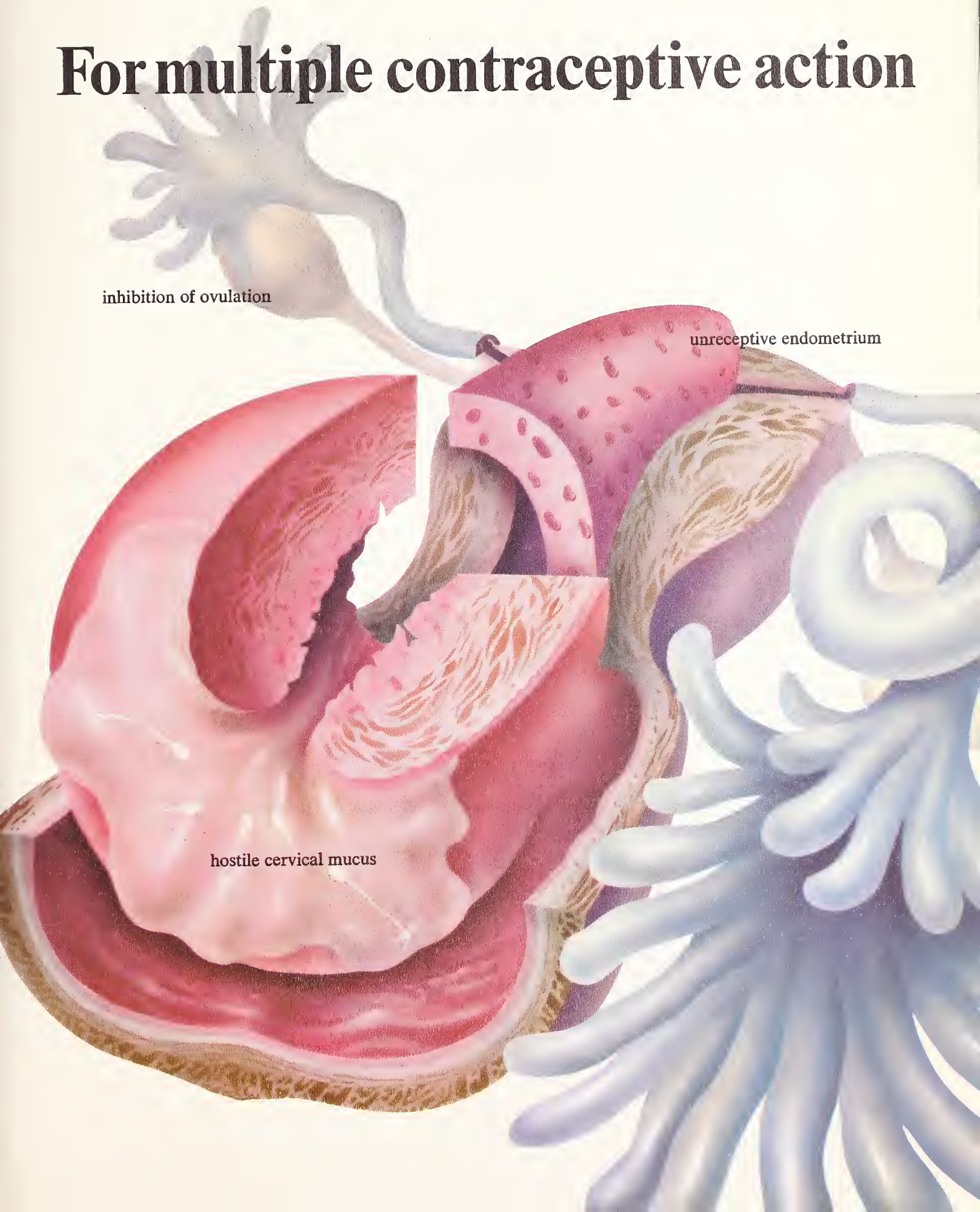
For multiple contraceptive action



Norinyl® tablets

(norethindrone 2 mg. c̄ mestranol 0.1 mg.)

multiple action that has produced a record of unexcelled effectiveness

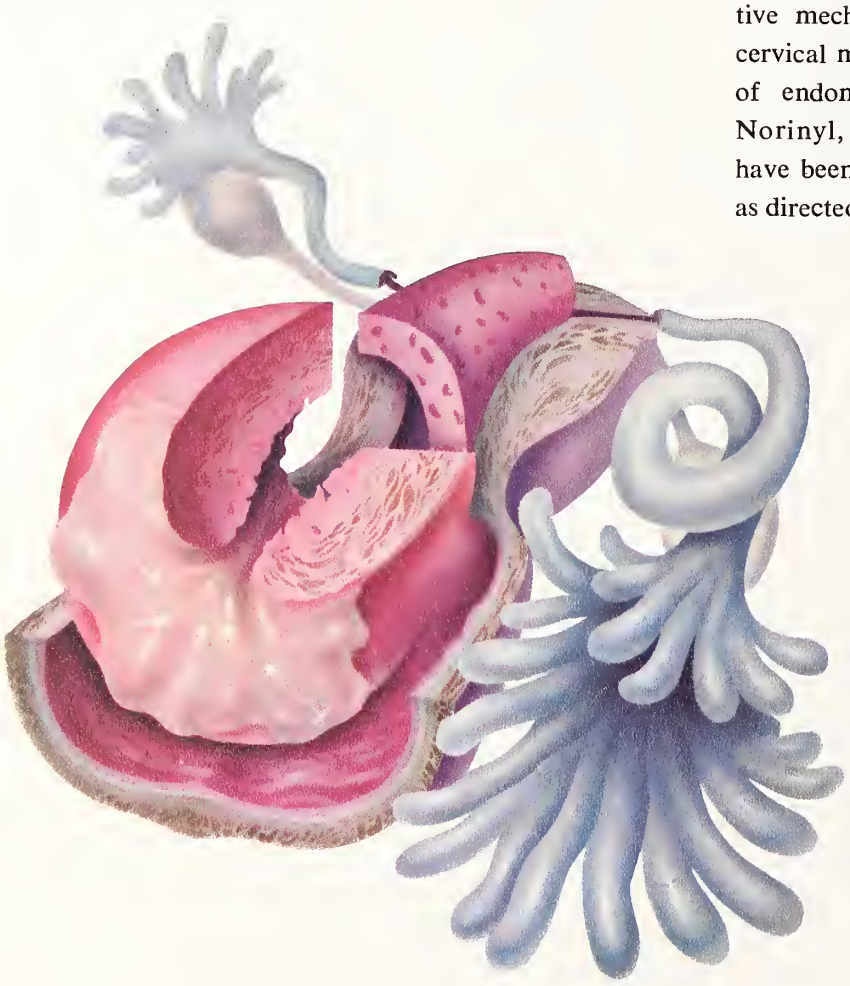
inhibition of ovulation by means of 2 time-proved hormonal agents

production of a cervical mucus hostile to sperm motility and vitality

creation of an endometrium unreceptive to egg implantation

no unplanned pregnancies

Norinyl provides multiple action for maximum assurance of success. It does not depend on ovulation inhibition alone for contraceptive effectiveness. The mechanism of action of combined hormonal therapy results in ovulation inhibition reinforced by other protective mechanisms, including a hostile cervical mucus[1-13] and an acceleration of endometrial changes.[1-3,7-16] With Norinyl, no unplanned pregnancies have been reported to date when used as directed.



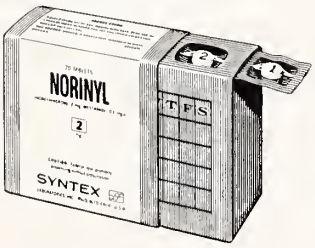
plus important supportive benefits that help her through those critical early months of oral contraception

low incidence of side effects

Low incidence of BTB and spotting, nausea and amenorrhea tends to minimize side effect problems and increases patient cooperation.

no confusion about dosage

An unbreakable "confusionproof" package makes it easy to adhere to prescribed dosage schedule: individually sealed tablets numbered from 1 through 20 *plus* monthly calendar record enables patient to double-check dosage intake by day and corresponding tablet number.



Contraindications: Thrombophlebitis or pulmonary embolism (current or past). Existing evidence does not support a causal relationship between use of Norinyl and development of thromboembolism. While a study which was conducted does not resolve definitively the possible etiologic relationship between progestational agents and intravascular clotting, it tends to confirm the findings of the Ad Hoc Advisory Committee appointed by the Food and Drug Administration to review this possibility. Cardiac, renal or hepatic dysfunction. Carcinoma of the breast or genital tract. Patients with a history of psychic depression should be carefully studied and the drug discontinued if depression recurs to marked degree. Patients with a history of cerebral vascular accident.

Warning: Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn.

Precautions: By May 1963, experience with norethindrone 2 mg.—mestranol 0.1 mg. had extended over 24 months. Through miscalculation, omission or error in taking the recommended dosage of Norinyl, pregnancy may result. If regular menses fail to appear and treatment schedule has not been adhered to, or if patient misses two menstrual periods, possibility of pregnancy should be resolved before resuming Norinyl. If pregnancy is established, Norinyl should be discontinued during period of gestation since virilization of the female fetus has been reported with oral use of progestational agents or estrogen. When lactation is desired, withhold Norinyl until nursing needs are established. Existing uterine fibroids may increase in size. In metabolic or endocrine disorders, careful clinical preevaluation is indicated. A few patients without evidence of hyperthyroidism had elevated serum protein-bound iodine levels, which in the light of present knowledge, does not necessarily imply hyperthyroidism. Protein-bound iodine increased following estrogen administration. Bromsulphalein retention has occurred in up to 25% of patients without evidence of hepatic dysfunction. Studies from 24-hour urine collections have shown an increase in aldosterone and 17-ketosteroids and decrease in 17-hydroxycorticoid levels. Thus, Norinyl should be discontinued prior to and during thyroid, liver or adrenal function tests. Because progestational agents may cause fluid retention, conditions such as epilepsy, migraine and asthma require careful observation. Thus far no deleterious effect on pituitary, ovarian or adrenal function has been noted; however, long-range possible effect on these and other organs must await more prolonged observation. Norinyl should be used with caution in patients with bone, renal or any disease involving calcium or phosphorus metabolism.

Side Effects: Intermenstrual bleeding; amenorrhea; symptoms resembling early pregnancy, such as nausea, breast engorgement or enlargement, chloasma and minor degree of fluid retention (if these should occur and patient has not strictly adhered to medication plan, she should be tested for pregnancy); weight gain; subjective complaints such as headache, dizziness, nervousness, irritability; in a few patients libido was increased. In a total of 3,090 patients, 2.2% discontinued medication because of nausea.

NOTE: See sections on contraindications and precautions for possible side effects on other organ systems.

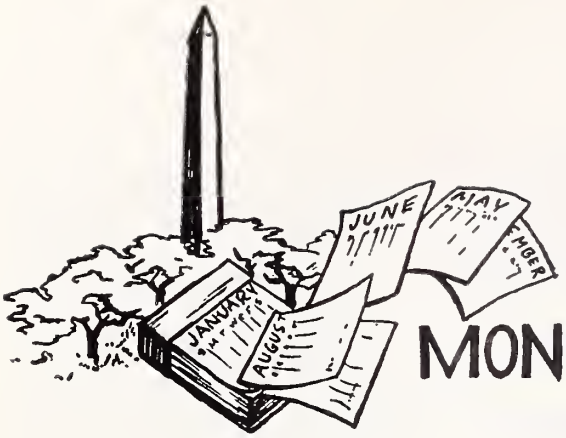
Dosage and Administration: One Norinyl tablet orally for 20 days, commencing on day 5 through and including day 24 of the menstrual cycle. (Day 1 is the first day of menstrual bleeding.)

Availability: Dispensers of 20 and 60 tablets; bottles of 100.

References: **1.** Council on Drugs. JAMA 187:664 (Feb. 29) 1964. **2.** Brvans, F. E.: Canad Med Ass J 92:287 (Feb. 6) 1965. **3.** Goldzieher, J. W.: Med Clin N Amer 48:529 (Mar.) 1964. **4.** Cohen, M. R.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965. **5.** Hammond, D. O.: Ibid. **6.** Rice-Wray, E., Coldzieher, J. W., and Aranda-Rosell, A.: Fertil Steril 14:402 (Jul.-Aug.) 1963. **7.** Goldzieher, J. W., Moses, L. E., and Ellis, L. T.: JAMA 180:359 (May 5) 1962. **8.** Kempers, R. D.: GP 29:88 (Jan.) 1964. **9.** Tyler, E. T.: JAMA 187:562 (Feb. 22) 1964. **10.** Rudel, H. W., Martinez-Manautou, J., and Maqueo-Topete, M.: Fertil Steril 16:158 (Mar.-Apr.) 1965. **11.** Flowers, C. E., Jr.: N Carolina Med J 25:139 (Apr.) 1964. **12.** Goldzieher, J. W.: Appl Ther 6:503 (June) 1964. **13.** The Control of Fertility. Report adopted by the Committee on Human Reproduction of the American Medical Association. JAMA 194:462 (Oct. 25) 1965. **14.** Flowers, C. E., Jr.: JAMA 188:1115 (June 29) 1964. **15.** Merritt, R. I.: Appl Ther 6:427 (May) 1964. **16.** Newland, D. O.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965.

norethindrone—an original steroid from
SYNTEX
LABORATORIES INC., PALO ALTO, CALIF.

Norinyl® tablets
(norethindrone 2 mg. c̄ mestranol 0.1 mg.)
for multiple contraceptive action



This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

MONTH IN WASHINGTON

WASHINGTON, D.C.—Health manpower and medical research are being reviewed in two comprehensive studies being conducted by the Federal government.

PRESIDENT JOHNSON called on the new National Advisory Commission on Health Manpower for an evaluation of the use of available government and non-government health manpower. He also asked for commission recommendations on expanding the supply of health manpower.

"THE NATIONAL DEMAND for health manpower today exceeds the supply— and this may be the case for several years," Johnson told the commission. "This fact gives your job a special importance . . . .

"FIRST, I need your advice about the Federal government's use of its health manpower:

—"Are we setting an example for the nation in the efficient use of health manpower?

—"Should we establish new forms of health manpower utilization?

"SECOND, we need answers to these same questions as they apply to non-federal health manpower.

"THIRD, we need your advice on how to develop additional health manpower— not only high-level specialists, but technicians and allied health professionals."

THE ADVISORY COMMITTEE met for the first time a few days after the House unanimously passed and sent to the Senate a bill to train more health workers. The measure sets up a three-year, $155 million program of aid aimed at training some 12,000 additional allied health workers such as medical technologists, therapists, x-ray technologists, dental hygienists, nutritionists and laboratory technicians.

THE LEGISLATION authorizes half the money for improving health worker training facilities and programs at qualified universities, colleges and junior colleges. The other half would go into a program of fellowship grants and federally guaranteed loans for students.

THE BILL also would authorize increased student loan forgiveness for physicians, dentists and optometrists who set up practice in poor rural areas where the supply of medical personnel is short or non-existent.

JOHNSON instructed 23 administration leaders in medicine and health matters, including Health, Education and Welfare Secretary John W.

Continued on page 884.

An eminent role in medical practice

- Clinicians throughout the world consider meprobamate a therapeutic standard in the management of anxiety and tension.
- The high safety-efficacy ratio of 'Miltown' has been demonstrated by more than a decade of clinical use.

Miltown®
(meprobamate)

Indications: Meprobamate is effective in relief of anxiety and tension states. Also as adjunctive therapy when anxiety may be a causative or otherwise disturbing factor. Although not a hypnotic, meprobamate fosters normal sleep through both its anti-anxiety and muscle-relaxant properties.

Contraindications: Previous allergic or idiosyncratic reactions to meprobamate or meprobamate-containing drugs.

Precautions: Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Usual adult dosage: One or two 400 mg. tablets three times daily. Doses above 2400 mg. daily are not recommended.

Supplied: 'Miltown' (meprobamate) is available in two strengths: 400 mg. scored tablets and 200 mg. coated tablets. 'Meprotabs' (meprobamate) is available as 400 mg. white, coated, unmarked tablets. *Before prescribing, consult package circular.*

WALLACE LABORATORIES
Cranbury, N.J.

CM-7814

When thiazide or reserpine alone won't keep

Establish and maintain early, more decisive control of blood pressure

DIUTENSEN®-R

Cryptenamine 1.0 mg.* Methyclothiazide 2.5 mg. Reserpine 0.1 mg.

When blood pressure won't stay down despite initial therapy—when complaints of headache, fatigue or dizziness are often voiced—it may be time for a change to DIUTENSEN-R.

DIUTENSEN-R is thiazide and reserpine *plus cryptenamine*—a rational, comprehensive therapy to help establish and maintain early, more decisive control of blood pressure.

The cryptenamine in DIUTENSEN-R helps improve normal vasodilating reflexes while the thiazide and reserpine components maintain vasorelaxant, sedative, and saluretic benefits. Cryptenamine lowers pressoreceptor reflex thresholds (which may be abnormally high in hypertension)—"resets" pressoreceptors to function at more nearly normotensive levels.

Early, more decisive control with DIUTENSEN-R helps secure continuing benefits—may reduce or even obviate the need for poorly tolerated drugs later in therapy.

"...quite apart from the problem of vascular damage, there arises a possibility of virtual 'cure' or remission of hypertension when treatment is early, i.e., before too many other secondary pressor systems have entered into the disequilibrium of pressor control, and when it is adequately suppressive."

Corcoran, A. C.: The choice of drugs in the treatment of hypertension. In: Drugs of Choice 1966-67, W. Modell, Ed., St. Louis, C. V. Mosby Company, 1966, p. 417.

Indications: DIUTENSEN-R may be employed in all grades of essential hypertension. **Dosages:** Usual dose is 1 tablet twice daily, at morning and evening meals. However, adjustment of dosage to suit individual circumstances may be required. Please refer to package insert for full particulars. **Side effects and precautions:** The side effects observed with patients on DIUTENSEN-R have been of a mild and nonlimiting nature. These include occasional urinary frequency, nocturia, nasal congestion, muscle cramps, skin rash, joint pains due to gout symptoms and nausea and dizziness which have been reported for the individual components. Most of these symptoms disappear while the drug is continued at the same or lower dosage level. The concomitant use of digitalis and DIUTENSEN-R may increase the possibility of digitalis-like intoxication. If there is evidence of myocardial irritability (extrasystoles, bigeminy or AV block), dosage of DIUTENSEN-R should be reduced or discontinued. Nocturia in patients with marginal cardiac status and salt and fluid retention can be effectively controlled by limiting the time of administration to early afternoon. DIUTENSEN-R should not be used in patients with a known intolerance to reserpine. Package inserts furnish a complete summary of recommended cautions related to each of the ingredients of DIUTENSEN-R.

*As tannate salts equivalent to 130 Carotid Sinus Reflex Units.

NEISLER UNION CARBIDE NEISLER LABORATORIES, INC. • DECATUR, ILLINOIS
SUBSIDIARY OF UNION CARBIDE CORPORATION

Continued

Gardner and the directors of national health institutes, to re-examine their priorities to determine whether research activities should be slowed down and more effort devoted toward making practical use of research findings.

HE ASKED for a report in a few months on a general reassessment of National Institutes of Health goals, effectiveness of current medical research programs, proportions of NIH funds being spent on basic research and on applied research, and major obstacles confronting the institutes in translating research findings into practical benefits.

THE PRESIDENT was reported to have shown concern in a meeting with his top medicine and health advisors that too much is being spent "for the sake of research alone." Similar concern has been voiced by some non-government individuals knowledgeable in the health field.

NATIONAL EXPENDITURES for medical research have increased from $87 million in 1947 to an estimated $1.85 billion last year. About two-thirds of the 1965 total was federal money and about four-tenths of the total was administered by the National Institutes of Health. In the two decades following World War II, NIH annual appropriations have zoomed from $3 million to $1.25 billion. In recent years, Congress voted NIH more money than the administration has requested.

"THE NATIONAL Institutes of Health are spending more than $800 million a year on biomedical research," Johnson said. "I am keenly interested to learn not only what knowledge this buys but what are the payoffs in terms of healthy lives for our citizens . . . .

". . . THE NATION faces a heavy demand on its hospitals and health manpower. Medical research, effectively applied, can help reduce the load by preventing disease before it occurs, and by curing disease when it does strike.

"BUT the greater reward is in the well-being of our citizens. We must make sure that no life-giving discovery is locked up in the laboratory."

FDA ISSUES NEW REGULATIONS

THE FOOD AND DRUG Administration has issued new regulations tightening the requirements for special diet foods and diet supplements.

THE REVISED REGULATIONS are aimed at providing the consumer with more facts about the foods for weight control, for dietary supplementation with vitamins and minerals, and for other special diet needs, such as controlling salt intake, according to Dr. James L. Goddard, the head of FDA.

THE NEW REGULATIONS set standards for certain foods to which nutrients may be added only if they have real value. A Recommended Dietary Allowances also is included as a guide to meeting nutritional needs.

THE NEW REGULATIONS will prohibit extravagant promotion of "shotgun" multi-vitamin and mineral supplements containing nutrients that meet no dietary need and tend to deceive the consumer.

Continued

Thanks to Dexamyl®

brand of dextroamphetamine sulfate and amobarbital

she can say "No thank you" to the crêpes suzette.

'Dexamyl' does more than most anorectics. Because it curbs appetite *and* lifts mood, 'Dexamyl' can encourage the discouraged dieter to stay on her diet.

The mood lift with 'Dexamyl' can make the difference between the success or failure of her diet plan.

Formulas: Each 'Dexamyl' Spansule® Capsule (brand of sustained release capsule) No. 1 contains 10 mg. of Dexedrine® (brand of dextroamphetamine sulfate) and 1 gr. of amobarbital, derivative of barbituric acid [Warning, may be habit forming]. Each 'Dexamyl' *Spansule* capsule No. 2 contains 15 mg. of Dexedrine (brand of dextroamphetamine sulfate) and 1½ gr. of amobarbital [Warning, may be habit forming].

Principal cautions and side effects: Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Insomnia, excitability and increased motor activity are infrequent and ordinarily mild.

Before prescribing, see SK&F product Prescribing Information.

Smith Kline & French Laboratories SK&F

Continued

THE REVISED labeling regulations and the new standards for fortified foods and vitamin and mineral supplements are scheduled to become effective in December.

A GENERAL REVISION of regulations on special dietary foods and vitamin-mineral supplements was proposed by the FDA four years ago. More than 50,000 comments were received on the provisions suggested at that time. The new regulations are the result of a review of the 1962 proposals and the comments and recommendations received about them.

GODDARD said the new requirements should sweep away many of the common misconceptions about the kinds and amounts of vitamins and minerals needed in the diet, and how they are obtained. He said "most Americans eat foods that provide all the vitamins and minerals normally required for good health."

MULTI-VITAMIN and mineral products will be required by the regulations to bear the following label:

> "Vitamins and minerals are supplied in abundant amounts by the foods we eat. The Food and Nutrition Board of the National Research Council recommends that dietary needs be satisfied by foods. Except for persons with special medical needs, there is no scientific basis for recommending routine use of dietary supplements."

THE PHARMACEUTICAL Manufacturers Association said that the new restrictions are "not in the public interest." A spokesman for the association said that when the Food and Drug Administration proposed similar regulations in 1962, "we found serious differences of opinion among nutritionists and other scientists as to the scientific basis for the proposals."

A SPOKESMAN for the National Health Federation, predicted that consumers will rebel against the regulations. He promised, "Congress will get more letters on this than on any other issue—any other." The federation is an organization of the manufacturers and distributors of unusual "health foods" and "super" vitamins.

THE DRUG AND ALLIED Products Guild, composed of smaller drug manufacturers and distributors, voted authority for its officers to assess the 97 regular members up to $500 each to hire special lawyers to prepare arguments against the FDA regulations. ◄

a Private Psychiatric Center at Jacksonville, Illinois, *since 1901*

Complete psychiatric treatment in an environment for cure. A 50 bed hospital with the most modern diagnostic and therapeutic equipment for the treatment of nervous and mental disorders.

LICENSED: Illinois Department of Mental Health.
MEMBER: Illinois Medical Service (Blue Cross-Blue Shield).

To lighten and clear blemished skin—without overbleaching or reactivity

Freckling, pigmented blemishes and skin discolorations gently fade away with Eldoquin. This exclusive new cream goes directly to the source of common skin blemishes. Applied one or two times daily, Eldoquin gradually lightens these areas to blend uniformly with the surrounding skin.

Eldoquin is mild: 2% Hydroquinone proved to be a remarkably safe bleaching agent during use tests on 380 patients ". . . no case of sensitization developed (in these tests)."[1]

Overbleaching is never a problem. Due to the transient action of Eldoquin, bleaching is gradual. Treatment can be easily adjusted to maintain a blemish-free complexion with uniform skin tone.

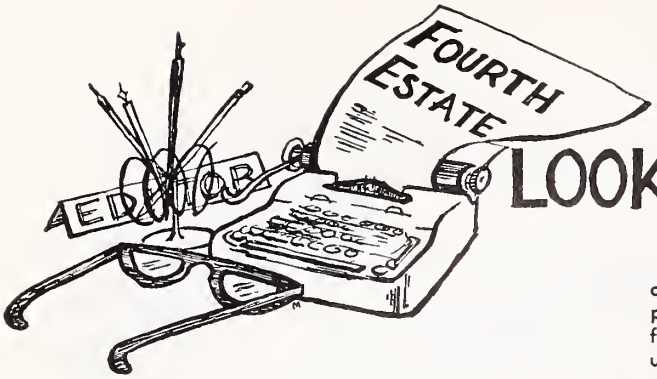
Contraindications: Do not apply to skin which is affected by prickly heat, sunburn, depilatory application, or is otherwise irritated. Do not use near eyes or open cuts.

Precautions: Before initiating treatment, sensitivity tests should be made, as follows: Apply cream to an area about the size of a quarter on inside of upper arm and rub in well. Allow to remain for 24 hours. If no redness or itching develops, proceed with the treatment. Do not expose treated area to sunlight for extended periods.

Supplied: ½ oz. tube.

References: 1. Spencer, Malcolm C. and Becker, S. W., Jr.: A Hydroquinone Effect, Clinical Medicine 70:6 (June) 1963. 2. Spencer, Malcolm C: Hydroquinone Bleaching, AMA Archives of Dermatology 84:131 (July) 1961.

PAUL B. ELDER COMPANY, Bryan, Ohio



LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

I.U. Medical Plan Would Keep Doctors In Indiana

The cause of Indiana's doctor shortage has never been a lack of school facilities. The state has 2.5% of the national population, and trains 4.5% of its doctors.

The trouble is that physicians don't stay in Indiana after they complete medical school. What we lack is not medical school facilities, but training hospital facilities — internships. Physicians practice, not where they attend medical school, but where they completed their training, and training for physicians is completed, in the formal sense, when they finish internships or residencies.

A proposal by Indiana University would remedy the ailment in the most immediate and practical way. It also could greatly improve medical care throughout the state by relating practice in the field directly to what is taught in medical schools.

The I.U. plan further would enable practicing physicians to keep in touch with academic developments and new medical techniques and drugs.

Indiana University President Elvis J. Stahr was not overstating the case when he said that the program should "produce more doctors sooner, will create more and better training for interns and residents in Indiana. It will add more significantly to the number of physicians in Indiana, and will more substantially increase the amount and quality of medical care in our state at substantially less cost than any other plan that has been proposed or that we can conceive." — *The Martinsville Daily Reporter.*

Why You Wait in Doctor's Office

Here's something to think about as you wait in your family doctor's office for two and three hours while your big toe throbs, your middle grumbles or your head aches.

Why do you have to wait so long?

Probably because there simply aren't enough family doctors in Indiana to take care of all the patients.

There aren't even enough specialists.

A simple check of listings in the Yellow Pages of the Muncie telephone book, marking out those you know have died, retired or moved away since last July, shows this:

There are 31 family doctors, the equivalent of one family doctor for each 3,645 persons in Delaware County.

There are 15 surgeons, the equivalent of one for every 7,400 persons in the city and county.

Internists, trained to be diagnosticians, find themselves practicing family medicine in Muncie because there simply aren't enough family doctors for all the families here.

There are 11 such internists (diagnosticians) in the city, one for each 10,000 people.

It's something to think about as you wait.

Muncie and Delaware County are the envy of many counties in Indiana which aren't as well off as we are in medical resources.

The U.S. Department of Health, Education and Welfare recommends a minimum of one doctor for every 1,000 population.

In Delaware County we have 91 physicians in private practice which gives us a ratio of one doctor for every 1,221 people.

Henry County has 31 physicians in private practice to take care of 48,-899 people — that's one doctor for every 1,609.

Grant County has 52 physicians in private practice to care for 75,741 people — or one doctor for every 1,456 people.

Wayne County has 56 physicians in private practice and a population of 74,039 — one doctor for every 1,323 persons.

Other Indiana counties are in much worse shape. Martin County in Southern Indiana has more than 5,000 patients per doctor. Five counties have more than 3,000 potential patients per doctor — Franklin, Scott, Spencer and Switzerland in southern Indiana and Warren County in northwestern Indiana.

Only Marion County and Indianapolis has a surplus of medical doctors, but Indianapolis doesn't have enough hospital beds.

If you get tired while waiting for your doctor, don't gripe to the nurse. Gripe to your legislators.

Only the Indiana General Assembly can really solve the crisis by approving increased medical education facilities for Indiana and appropriating the money to do it right. A second school is a prime need. — *Muncie Evening Press,* June 8, 1966.

Retain The Doctors

It is understandable that the graduate of a medical school is likely to begin his practice in the area in which he was a hospital intern or resident.

During the time spent in this postgraduate work he has become familiar with the area, the needs of the people and the opportunities offered for the new young doctor.

Nevertheless, this tendency has created a serious problem for Indiana as it has resulted in too many doctors educated in the state seeking to establish their practice elsewhere.

The solution of the problem would seem to be to make available more internships and residencies for medical students within the state. And that is the conclusion reached by three Indiana University professors who have made a report, "Growth and Change at Indiana University," after a year-long study.

The report describes the number of available internships and residencies in Indiana as especially low. In 1965 there were only 383 residencies in Indiana and 201 of these were at the I.U. Medical Center. By way of contrast, Illinois offered 2,010, Michigan, 1,945, Ohio, 2,251 and Kentucky, 423. As for internships in the fall of 1965, Indiana had only 139, while Illinois had 757, Michigan, 562, Ohio, 812 and Kentucky, 117.

If the tendency to locate in the states where the students receive such training is a fact, and statistics suggest it is, then the neighboring states are far better off than Indiana as far as number of doctors is concerned.

Indiana cannot afford to permit the number shortage of doctors to become any worse. Nor does it seem appropriate that the medical students educated at a state-supported school should go elsewhere to practice.

Even a new medical school would not solve the doctor shortage unless the internship and residency programs in the state increase. Graduates of the new school would be taking their postgraduate training elsewhere and many would not return to Indiana to practice.

As a solution, the report suggests the possibility of establishing programs for interns and residents in many major hospitals in Indiana which do not now have them. It also suggests further that if the state paid half the costs of such a program, it would be much cheaper than the expense of creating and maintaining a new medical school.

There is no question of the need for more doctors in Indiana. The method suggested in the report appears to be effective, as it has logic and common sense. It deserves serious consideration. — *The Indianapolis News*, June 21, 1966.

The Case of the Therapeutic Establishment

The problems and responsibilities of government in assuring the safe use of drugs are indeed formidable . . . . This brings up the whole question of efficacy and of relative efficacy; and who is going to dogmatize on this?

Again, who is going to say that the occasional fatal toxic reactions which may result, for instance, from the use of psychotrophic drugs in depressive illnesses are or are not greater than the danger of an increased incidence of suicide if such drugs are forbidden. Doubtless a committee of experts will advise the appropriate ministers, and if experts are occasionally wrong, they are less often wrong than non-experts.

Nevertheless, we interfere with the prescribing doctor's final freedom of decision at our peril in a free democracy. It is easy to set up a sort of pontifical therapeutic Establishment; but Establishments — Aristotle and Galen, for instance — have not always been in the van of progress. — Sir Derrick Dunlop, M.D., in *British Medical Journal*, (2:440-441), August 21, 1965.

Letter to the editor

May 28, 1966

Frank B. Ramsey, M.D.
1802 N. Illinois St.
Indianapolis, Ind.

Dear Doctor Ramsey:

In regard to the letter "To All My Patients" on page 496 of your May issue of *JISMA* I would call your attention to the following errors:

1. Every doctor should understand all implications of Medicare.
2. Every doctor must learn about the political economy.
3. Congressmen usually know less about Medicare or other phases of federal usurpation of personal responsibility than the average intelligent citizen, and patients should not be instructed to direct inquiry to them for a sensible answer.
4. So-called "experts" in the economic-legal-political field are the propagandists for one-world socialism and their evil would be augmented by directing patients to get answers from them.

Citizenship responsibilities of our profession are ignored by the promotion of this "form letter."

Sincerely yours,
A. G. Blazey, M.D.
7 E. Walnut
Washington, Ind.

Four of every five traffic accidents in 1965 could have been avoided, according to The Travelers Insurance Companies. The major cause of death and destruction on U.S. highways, says Travelers, is driver error and lack of judgment.

* * * *

Nearly 275,000 pedestrians were injured and 9,000 were killed during 1965 in the United States, according to The Travelers Insurance Companies. This includes 300 persons who were injured while actually standing on a traffic safety isle!

WANTED: Locations Physicians

GENERAL PRACTICE

Eugene J. Carlin, 232 Lorenz Rd., San Antonio, Texas

D. (Dominick) Coriale, 1244 Hillview Dr., Utica, New York 13501

Vernon T. Watley, 301 Main St., Vega, Texas

Roberto Garcia-Rivera, 912 Cereal Ave., Hamilton, Ohio 45013

David E. MacQuigg, Surgeon Hq. 1 Corps (gp), APO 96358, San Francisco, Calif.

Rene' Martin Jacobs, Madison State Hospital, Madison, Ind. 47251

F. S. Dino, Box 155, Aberdeen, Ohio 45101 — with *Surgery*

Robert F. Gilbert, 5463 Delmar Blvd., Apt. 318, St. Louis, Mo. — with *Surgery*

Ramon V. Banez, 20203 Longbrook, Cleveland, Ohio 44128 — with *Surgery*

SPECIALISTS

Martin L. Norton, 217-35 Kingsbury Ave., Flushing, N. Y. 11364 — *Anesthesiology*

Thomas W. Weis, 12121 Juniette St., Culver City, Calif. 90230 — *Anesthesiology*

Hilmi O. Arseven, P.O. Box 813, Logan, West Va. 25601 — *Anesthesiology*

Logan A. Griffin, 3 Serpentine Dr., New Rochelle, N. Y. 10801 — *Anesthesiology*

Maurice Ghaly, Veterans Hospital, Providence, Rhode Island — *Anesthesiology*

Duane Wombolt, 1520-1 W. 6th Ave., Columbus, Ohio — *Internal Medicine*

Hugh B. Higginbotham, 80 Totten St., Fort Leonard Wood, Mo. — *Internal Medicine*

Fenton M. Mitchell, Buffalo General Hospital, Buffalo, N. Y. — *Internal Medicine*

Daikichi Hata, 329 Main St., Boonville, Mo. 65233 — *Internal Medicine*

Manuel Valera, Box 65, Cleveland Clinic, Cleveland, Ohio — *Internal Medicine & Vascular Diseases*

Ralph R. Reed, 339 15th Ave., S.W., Rochester, Minn. — *Internal Medicine*

Anthony M. Tanno, 1464 E. Queen St., Annville, Penn. 17003 — *Internal Medicine*

Mahfouz H. Rizk, 13205 Cranwood Pk. Blvd., Garfield Heights, Ohio — *Ob-Gyn.*

Raymond M. Michols, 3804 El Camino, Las Vegas, Nev. 89101 — *Orthopedics*

Isabel Ng Gerundo, Philadelphia State Hospital, Philadelphia, Pa. — *Pathology*

Ruperto F. Colmenares, 1701 Bern Rd., Apt. 0-1, Wyomissing, Pa.—*Pathology*

Thomas M. Jackson, 200 E. Hills Terrace, Dickson, Tenn. — *General Surgery*

Billy P. Sammons, 2931 Sherer Dr., Richmond, Va. — *Radiology*

Ivan H. Carper, 4010 Springfield St., Kansas City, Kans. 66103 — *General Surgery*

Calvin Y. Hadidian, 600 McMullen Highway, Cumberland, Md.—*General Surgery*

Harvey P. Rubin, 215 E. Tilden St., No. 3, Dallas, Texas 75203 — *General Surgery*

William D. Moyle, 43 Davenport Ave., New Rochelle, N.Y. — *General Surgery*

V. F. Raymundo, 103 E. Washington St., Attica, Ind. — *General Surgery*

Robert G. Sheperd, 104 North Main St., West Unity, Ohio — *General Surgery*

Ronald P. Grunwald, 3235 Cambridge Ave., Riverdale, N.Y. — *General, Cardio-Thoracic Surgery*

Gur Sharan Singh, 3801 University St., Montreal, Quebec, Canada — *Neurosurgery*

Jorge G. Echenique, 6066 S.W. 25th St., Miami, Fla. — *Urology*

Moses Saiphoo, Suite 415, 9 Crown Hill Pl., Toronto, Canada — *Urology*

Lawrence L. Levy, 32 Gramercy Park South, New York, N.Y. 10003 — *Urology*

LOCATIONS—GENERAL PRACTICE

County *Town*

Blackford — HARTFORD CITY — population 8,050. Need for two general practitioners. County seat town with a 51-bed hospital. For further information contact Chamber of Commerce, Box 286, Hartford City, 47348.

Benton — EARL PARK — Small community of 600 located in the heart of a rich farming area. Building which was erected in 1946 especially for a doctor's office is available. The community has the schools, churches and financial income to support a medical doctor who wants to live in the country. For further details contact Mr. William Gamso, Earl Park, 47942.

FOWLER — population 2,100. County seat town. Rich farming area. Large surrounding area. Only six active physicians in the county which has a population of over 11,000. For details contact Larry Coddens, M.D., Fowler, 47944. Telephone 317—844-1350.

Cass — LOGANSPORT — population 21,-700. Two hospitals. Opening for internist. Primary source of income — industry, railroads and farming. Contact Paul H. Wilson, M.D., 422 North St., Logansport, 46947.

WALTON — population 850 with a population of 8,000 in the immediate area. Located in central Indiana halfway between Logansport and Kokomo where hospital facilities are available. Principal economy is farming. Community is building a new facility, using the plan developed by the Sears-Roebuck Foundation. For further information contact Mr. Roger Rhodes, Walton, 46994.

Clay — BRAZIL — population 9,000 with a population of 15,000 within a five-mile radius. County population 25,000. Located 15 miles from Terre Haute on U. S. 40. New county hospital. Office space available for general practitioner with a group of physicians. Contact Everett H. Conrad, M.D., Brazil, 47834.

CLAY CITY — population 1,100. Located south of Brazil on State Road 59. Large surrounding area without the services of a physician. Contact Forrest R. Buell, M.D., Clay City, 47841.

Clinton — COLFAX — population 800. Located close to Lafayette and Frankfort where hospital facilities are available. Community without the services of a physician. Large surrounding area; rich farming area. Contact Mr. John Gilmore, P. O. Box 187, Colfax, 46035.

MULBERRY — population 1,100 with a surrounding population of 2,000. Located 10 miles from Lafayette, home of Purdue University, and two excellent open staff hospitals. Ten miles from Frankfort, county seat, where the 83-bed county hospital is located. Mulberry is located in a rich farming area. No physician in the community. Contact Mr. Eldon Skiles, Farmer's Bank and Mrs. Bert V. Livelsberger, 517 W. Perrin Street, Mulberry, 46058.

Crawford — ENGLISH — population 700 — county population 8,310 located in southern Indiana. Principal economy is agriculture. One resident physician in county who is past 70 years of age. Crawford Medical Clinic which will accommodate two physicians is being built under the direction of the Sears-Roebuck Foundation. Contact Mrs. Kenneth J. Luckett, Secretary, English Civic Club, Box 115, English, 47118.

Daviess — MONTGOMERY — population 600 — located seven miles from Washington and Loogootee. No physician in the community. Contact Mr. Fred P. Murphy, Montgomery, 47558. 138-bed county hospital located in Washington.

Decatur — GREENSBURG — population 10,-000. Industrial and farming community located between Indianapolis and Cincinnati, Ohio; 84-bed hospital with new facilities there. Need for four general practitioners. Contact Edward Kucinski, Administrator, Decatur County Hospital, Greensburg, 47240.

Delaware — MUNCIE — population 70,000. Opening for doctors specializing in internal medicine and pediatrics. 12,000 student Ball State University located here with its cultural benefits. Ball Memorial Hospital has 450 beds and 150 bed addition now under construction. Contact Mr. Pence, Manager, Muncie Clinic, 420 W. Washington St., Muncie, 47305.

Fayette — CONNERSVILLE — population 18,000. There is a need for two general practitioners and an eye, ear, nose and throat specialist. Several manufacturing concerns located in the community. Coun-

ty hospital of 67 beds available. Contact Bev Dixon, Ex. Vice-President, Chamber of Commerce, 111 W. 7th St., Connersville, or J. L. Steinem, M.D., 818 Grand Ave., Connersville, 47331.

Fountain — HILLSBORO — population 600. Located 14 miles from the 83-bed Montgomery County Culver Union Hospital in Crawfordsville, home of Wabash College. No physician in the community. Office available which will be rent free for six months. Contact Mr. R. M. Osborn of the Booster Club, Hillsboro, 47949.

VEEDERSBURG — population 2,500 with a large surrounding area. One physician in the town. Hospitals located at Crawfordsville, 20 miles away and Danville, Illinois, 20 miles to the west. Also a small hospital at Williamsport which is 16 miles. Primary sources of income are from farming, steel castings foundry and brick factory. Olin-Mathieson plant nine miles west. Contact Mr. Vern French, Secretary, Lions Club, 117 E. Second St., Veedersburg, 47987.

Fulton — LEITERS FORD — Merchants Association interested in obtaining a physician for the community which is located 13 miles from Rochester where hospital facilities are available — 64-bed hospital. Contact Mr. Ernest L. Hiatt, Leiters Ford, 46945.

Gibson — HAUBSTADT — located in the southwestern part of Indiana — population 1,200. Principal economies are farming, meat packing and light manufacturing. Large tourist attraction farm nearby is developing. Located 16 miles from Evansville and 12 miles from Princeton where hospital facilities are available. Fifty-five room nursing home is under construction. New office facilities for a doctor are available located near two major highways — U. S. 41 and I-64. Contact Mr. Ted Will, Will's Corner, Haubstadt, 47539.

OWENSVILLE — population 1,100 with a large surrounding territory, mainly farming community. Twenty-five miles from Evansville where three hospitals are available and 15 miles from Princeton where a new 80-bed hospital is located. No physician in the community. Office available. Contact Marion E. Warpenburg, D.D.S., Owensville, 47453.

Grant — SWEETSER — population 1,000. Located close to Marion where hospital facilities are available. No physician in the town. For further information contact Mr. R. H. Allen, Clerk, Town of Sweetser, Sweetser, 46987.

UPLAND — population between 2,000 to 2,500. Principal economies are industry, agriculture and education. Home of Taylor University which has an enrollment of 1,250 students. Located 14 miles from Marion and eight miles from Hartford City where hospital facilities are available. One physician in the community who has a limited practice. New industries locating in the community. Citizens of the community as well as officials at Taylor University willing to cooperate in helping a physician establish a practice. Contact Mr. Hugh Freese, P. O. Box 248, Upland, 46989. Telephone 998-2125.

Greene — WORTHINGTON — population 1,700. Nearest hospital (73 beds) is located at Linton which is 13 miles distant. New gypsum plant being started. Office available. Contact Mr. G. E. Conway, 2 Washington St., Worthington, 47471.

Hamilton — NOBLESVILLE — population 7,600. Located 25 miles north of Indianapolis. County seat with an 86-bed county hospital. Contact Haldon C. Kraft, M.D., 195 S. 10th St., Noblesville, 46060. Telephone 773-0284.

Hendricks — DANVILLE — population 4,200. County seat town with a 70-bed county hospital. Located 18 miles from Indianapolis on U. S. 36. Need for general practitioners. Contact Mr. Bill Falls, 64 S. Jefferson St., Danville, 46122.

Henry — MT. SUMMIT — population 500. Five miles from New Castle where hospital (194-bed) facilities are available. Mixed farming and industrial area. Several small communities within a radius of ten miles without a physician. Contact Mr. Tom Bowers, Clerk-Treasurer, or Mr. R. L. Beavers, Mt. Summit, 47361.

SULPHUR SPRINGS — population 400. Rural community. Located eight miles from New Castle. Contact Alfred C. Ayres, Cashier, Union State Bank, Sulphur Springs, 47388.

Howard — GREENTOWN — population 1,300. Located nine miles from Kokomo where two hospitals are available. Most any kind of office required is available. Community needs and can support another physician. Contact Mr. Richard Zirkle, 508 E. Main St., Greentown, 46936. Telephone 317—628-7718.

KOKOMO — population 50,000. Two hospitals. Openings for general practitioner and internist with a four-man group (one surgeon, two general practitioners and one Ob-Gyn) operating out of a new 18-room clinic soon to be enlarged. Will have fully equipped laboratory, two minor surgeries, x-ray, and private physicians offices. Contact Mr. Robert E. Thompson, Business Manager, 401 E. Reynolds Dr., Kokomo, 46902. Phone Kokomo 453-0805.

KOKOMO — Need for several general practitioners. Contact Dr. Charles Smith, Howard Community Hospital, 3500 S. Lafountain, secretary of the Howard County Medical Association, for details.

Huntington — ANDREWS — population 1,300. Located five miles from Huntington where a 100-bed county hospital is located. Several factories in the community. Community will assist financially. Contact Mr. George E. Wintrode, 578 McKeever St., Andrews, 46702.

HUNTINGTON — population 16,185. Office of the late Dr. F. B. Mitman who practiced in Huntington for 40 years available. Need for general practitioner. Huntington County Hospital (100-beds) located in town, 25 miles from Fort Wayne. Contact Don Klepper, Huntington, 46750. Telephone 356-8700.

WARREN — Opening for a physician for the Methodist Memorial Home which is completely owned and controlled by the North Indiana Conference of The Methodist Church. Present membership 375. More than 160 rooms in the hospital section of the home. Salaried position. For details contact Dr. D. C. Souder, Executive Secretary, The Methodist Memorial Home, Warren, 46792.

Jackson — BROWNSTOWN — population 2,500 with a drawing population of 18,000. Ten miles from a 100-bed county hospital at Seymour. Contact Mrs. Keith Smallwood, Secretary, Brownstown Chamber of Commerce, Brownstown, 47220.

MEDORA — population 900. Located in the south central part of Indiana. The principal economy is small industry and agriculture. Large surrounding rural area. No physician in the town. Office and house available. Located 20 miles from Bedford, Seymour and Salem where hospital facilities are available. Contact Mr. Bernard Toon and Mr. Ed Kasting, Medora, 47260.

Jay — PENNVILLE — population 700. Town without a physician. Located 12 miles from Portland and 17 miles from Bluffton. Lions Club interested in securing a physician. Contact Mr. Earl Christman, Pennville, 47369.

Johnson — MT. PLEASANT & SMITH VALLEY COMMUNITIES — Located in the northern part of Johnson county — eight miles from Franklin where a 128-bed county hospital is located. New office available or will build to suit the tenant. Northern Johnson county is one of the fastest growing areas in the state. For details contact Mr. Robert McDonald, Box 194, Greenwood, 46142. Phone Tucker 1-4879.

There are openings for general practitioners in Edinburg, Franklin, Greenwood and White River Township. For details contact Robert W. Ogle, M.D., 360 S. Madison Ave., Greenwood, secretary of the Johnson County Medical Society.

EDINBURG — population 4,000 with a

large potential area. Located ten miles from county hospitals at Franklin and Columbus. Office and housing available. No full-time physician in the town. Contact Rev. Carl Boyer, Box 175 or Mrs. Dale Amos, Frost Hill, Edinburg, 46124.

Kosciusko — WARSAW — population 7,200 with a three mile radius population of 12,000. Located in the northern part of Indiana in the lake region; 68-bed hospital in the town. Contact Thomas Keough, M.D., 600 E. Winona Ave., Warsaw, secretary of the Kosciusko County Medical Society or William Cron, M.D., 827 S. Union Street, Warsaw, 46580.

Lake — GARY — General practitioner, orthopedic surgeon and ophthalmologist to join 19-man clinic. New clinic building with complete x-ray and laboratory facilities. Two excellent open staff hospitals. Contact R. Lyle Foster, The Gary Clinic, 6111 Harrison St., Gary, 46408.

Lawrence — MITCHELL — population 4,000, located in the south-central part of Indiana. The principal economies are industry and farming. Ten miles from Bedford where hospital (100-bed) facilities are available. One physician in the town, 65 miles from Louisville, Kentucky. Contact Mr. Virgil Taylor, Secretary, Mitchell Chamber of Commerce, Mitchell, 47446.

Madison — SUMMITVILLE — population 1,200. Opening for a general practitioner to associate with William C. Van Ness, M.D., only physician in the town, in a clinic. Contact Doctor Van Ness, Summitville, 46070.

Marshall — ARGOS — population 1,300. Located close to Plymouth where the Parkview Hospital (54 beds) is located. Contact J. N. Hampton, M.D., 530 N. Michigan, Argos, 46501.

CULVER — population 1,700. Located in the lake region of northern Indiana. Home of Culver Military Academy; 14 miles from Plymouth. Opening for an associate or partner in general practice. Contact Joseph Howard, M.D., 921 Lake Shore Dr., Culver, 46511.

Miami — BUNKER HILL — population 700 with a large surrounding area without the services of a physician. Located near Bunker Hill Air Force Base. Hospital located in Peru (79 beds). Contact Mrs. Jess Abplanalp, Bunker Hill, 46914.

Montgomery — WAVELAND — population 500. Twelve miles from Crawfordsville. Lions Club interested in having a physician locate there. Contact Mr. J. Lowell Spencer, Waveland, 47989.

Newton — LAKE VILLAGE — farming community with a surrounding population of 3,000. Closest physician located 12 miles distant. Hospital facilities are available at Brook which is 20 miles away. Contact Mr. Bill H. Wright, Box 245, Lake Village, 46349.

Noble — ALBION — population 1,500. Progressive community in the heart of the Indiana lake region — county seat town. Community can easily and readily support one more general practitioner. Contact Albion Chamber of Commerce and Mr. Jerry D. Morr, 410 S. Oak, Albion, 46701.

CROMWELL-KIMMELL community is interested in having a general practitioner. Located in the northern part of Indiana in the lake region. Contact Mr. Gene Leedy, Secretary, Cromwell Business Association, Cromwell, 46732.

Posey — CYNTHIANA — population 600 — located in the southwestern part of Indiana 20 miles from Evansville where hospital facilities are available. The principal economies are agriculture and industrial employment. A non-profit corporation, Cynthiana Medical Center, Inc., has been formed. Contact E. F. Heiser, President or Miss Helen M. Martin, Secretary, Cynthiana, 47612.

MT. VERNON — population 7,000 — located close to Evansville. Doctor shortage has become acute. Posey County Medical Society and the Chamber of Commerce interested in securing physicians for the community. Contact Mrs. Bess L. Mangis, Executive Secretary, Mt. Vernon Chamber of Commerce or Herman Hirsch, M.D., secretary of the Posey County Medical Society, Mt. Vernon, 47620.

Pulaski — WINAMAC — population 2,200. Forty-bed general hospital. Three active physicians in the town. For details contact W. R. Thompson, M.D., 111 N. Monticello and E. L. Hollenberg, M.D., 210 S. Market St., Winamac, 46996.

Putnam — COATESVILLE — population 450. Located 14 miles from Greencastle, home of DePauw University, where hospital facilities are available — (79 beds). Contact John Ellett, Jr., M.D.

GREENCASTLE — population 8,500. DePauw University is located here, as is Putnam County Hospital (79 beds). There is a need for general practitioners. Contact J. B. Johnson, M.D., 105 E. Washington St., Greencastle, 46135.

Randolph — WINCHESTER — population 6,000 with a trade area of 12,000 to 15,000. Randolph County Hospital (60 beds) located in town. Agricultural and industrial community. Need for two or three general practitioners. Contact Mr. William R. Hunter, 111½ W. Washington St., or C. R. Slick, M.D., 457 Elm St., Winchester, 47394.

SARATOGA — population 350. Located in the east central part of Indiana. The principal economies are farming and employment in Winchester. Contact Mr. Harold L. Girton, Office of the Town Board, Saratoga, 47382.

Ripley — FRIENDSHIP — large rural area in need of a physician. Located close to Madison, Batesville and Lawrenceburg where hospital facilities are available. Contact Mrs. Henry D. Fisse, Friendship, 47021.

St. Joseph — NORTH LIBERTY — population 1,200. For sale or lease, 1,200 square foot office building. Will sell equipment, drugs and supplies on contract with low down payment. Going, active practice, no other physician in town. Fifteen miles from South Bend where hospital facilities are available. Contact O. Walter Calvin, M.D., North Liberty, 46554.

Scott—SCOTTSBURG—Population between 4,000-5,000. County seat town. New 36-bed hospital. Large surrounding territory without the services of a physician. County medical society interested in having general practitioners located in Scottsburg. Contact James Sabens, M.D., 69 Wardell St., Scottsburg, 47170, secretary of the Scott County Medical Society.

Shelby—SHELBYVILLE—population 14,000. William S. Major Hospital (110 beds) located there. There is a need for general practitioners. Contact R. F. Whitcomb, M.D., 120 W. Jackson St., Shelbyville, 46176.

Spencer — ROCKPORT — population 2,500. County seat town. Large surrounding area without the services of a physician. Contact M. O. Monar, M.D., and J. C. Glackman, Jr., M.D., Rockport, 47635.

ST. MEINRAD — Located 50 miles northeast of Evansville and 75 miles from Louisville, Kentucky. Tri-state Highway to be located close by. Population 800 with a large drawing area. Modern four room office available. Hospitals located in Huntingburg (60 beds) and Tell City (58 beds). Huntingburg is 17 miles from St. Meinrad and Tell City is 19 miles. Community provides an excellent future for anyone desiring a rural general practice. Contact Mr. Othmar Ringeman, St. Meinrad Development Corporation and Mr. Ottis N. Schatz, St. Meinrad, 47577.

Starke — KNOX — population 4,000 — county seat town. Located in the lake region of northern Indiana. Forty-bed hospital to be doubled in size. Money has been appropriated and approved — building to start any time. Five physicians in county. Opening for general practitioner, surgeon and anesthesiologist. For further information contact J. F. DeNaut, M.D., 4 N. Heaton St., Knox, 46534.

Sullivan — CARLISLE — population 900. Located nine miles from Sullivan, county seat, where hospital facilities are available (116 beds). Hospital has been remodeled,

new addition contains the latest in surgical equipment. Contact J. S. Brown, M.D., Carlisle, secretary, Sullivan County Medical Society and Mrs. Josephine Ridgway, Carlisle, 47838.

Switzerland — VEVAY — population 1,700. County seat town. Located close to Madison, on the Ohio River, midway between Cincinnati, Ohio and Louisville, Kentucky. The people of the community have helped expand facilities of the one full-time physician to provide space for another doctor or they will be willing to help provide separate facilities. New industry entering community. Contact Mr. H. C. Benedict, Superintendent, Switzerland County Schools, Vevay or Mr. Raymond Osborn, Jr., President, Chamber of Commerce, Vevay, 47043.

Tippecanoe — BATTLE GROUND — population 900 with a surrounding population of 2,000. Eight miles from Lafayette where hospital facilities are available. Office and home available. Contact Mr. Floyd Garrott, Battle Ground, 47920.

WEST POINT — population 350 with a surrounding population up to 15,000. Located close to Lafayette in the west-central part of Indiana. The principal economies are farming and employment in Lafayette, which is 12 miles distant. New medical unit is completed. This unit was constructed under the direction of the Lions Club with 225 families contributing funds. Contact Mr. Charles R. DeVault, Box 163, West Point, 47992.

CLARKS HILL — population 700. Located 11 miles west of Frankfort and 16 miles south of Lafayette. Contact George E. Lee, Box 54 or Mr. Paul Marks, Postmaster, Clarks Hill, 47930.

Vanderburgh — DARMSTADT — Village Square Shopping Center located six miles from Evansville. Three hospitals in Evansville. Space available for an office. Need for general practitioner or internist. Growing community with approximately 1,800 homes and 7,000 persons in a four-mile area. Prescription drug store in complex. Contact Robert L. Willner, Village Square Shopping Center, R. R. No. 5, Box 117, Evansville, 47711.

Vermillion — PERRYSVILLE — population 500. Located in a rich farming area along the Wabash River. Fifteen miles from Danville, Illinois and 25 miles from Clinton, where hospitals are located. Contact Mrs. Sara M. Sheridan, Perrysville, 47974.

NEWPORT — population 700. County seat town. Hospital facilities available at Clinton (72-bed hospital). Located in the west central part of Indiana. Principal economies are farming and industrial work in neighboring towns. Contact Mr. William W. Bishop, P. O. Box 187, Newport, 47966.

Warrick — BOONVILLE — population 5,100. Located 15 miles from Evansville where hospital facilities are available. There is a need for general practitioners. Only six physicians in the county. Contact Don Julian, Julian's Rexall, Boonville, 47601.

NEWBURGH — population 1,350. Located five miles from Evansville. Contact C. M. Wilhelmus, M.D., Newburgh, 47630.

Wayne — CAMBRIDGE CITY — population 2,600 with a surrounding area of 8,000. Fully equipped office available due to death of a physician. Hospitals at New Castle (194 beds), Richmond (367 beds) and Connersville (67 beds) within a 15 mile radius. Contact Robert A. Cox, D.D.S., 3 Parkview Court, Cambridge City, 47327. Telephone 35191.

MILTON — population 800. Community without a physician. Located close to Richmond. Office available. Contact Mr. Oscar Fain and Mrs. Irvin Lemmons, Milton, 47357.

RICHMOND — population approximately 50,000. There is a need for several physicians. Reid Memorial Hospital (367 beds) located there. Also Earlham College is in Richmond. Modern and thriving city. Contact either William R. Stilwell, M.D., 2607 South C Place or Charles V. Sage, M.D., 48 S. 11th St., Richmond, 47374.

White — CHALMERS — population 500. Located in the northwestern part of Indiana in an agricultural area. Twelve miles from Monticello where the White County Memorial Hospital (48 beds) is located. Contact Charles M. Burget and John Tully, Chalmers, 47929.

MONON — population 1,500. Located close to Lafayette and Monticello where hospitals are located. Contact Mr. Thad Hanway, Monon, 47959.

MONTICELLO — population 3,500. County seat town with county hospital (48 beds). Contact Martin E. Tullis, administrator of the White County Memorial Hospital, Monticello, 47960.

Whitley — CHURUBUSCO — population 2,000 with a surrounding trading area of 10,000. Located 10 miles from Columbia City and 14 miles from Fort Wayne where hospital facilities are available. Fully equipped office available. Contact Mr. R. J. Krider, Churubusco, 46723.

SOUTH WHITLEY — population 1,500. Located in the lake region of northern Indiana. Twenty miles from Fort Wayne where three hospitals are located. Office available. Contact Mrs. Tom Newell, secretary, South Whitley Chamber of Commerce and Mr. Floyd Bolinger, R. R. 1, South Whitley, 46787.

LOCATIONS — SPECIALISTS

County *Town*

ANESTHESIOLOGY

St. Joseph — SOUTH BEND — population 132,445. Two hospitals — one has 374 beds and the other 344 beds. Home of Notre Dame University located in northern Indiana. Contact Mr. Harry Davis, Executive Secretary, St. Joseph County Medical Society, 106 W. Monroe St., South Bend, 46601.

Wells — BLUFFTON — population 6,250. Opening for anesthesiologist. Clinic Hospital (164 beds). Contact W. E. Symon, M.D., Caylor-Nickel Clinic, 303 S. Main St., Bluffton, 46714.

DERMATOLOGY

Grant — MARION — population 37,850. Opening for dermatologists in Marion. Contact Robert G. Young, M.D., Secretary, Grant County Medical Society, 1207 Northwood Court, Marion, 46952.

EAR, NOSE and THROAT

Grant — MARION — population 37,850. Marion General Hospital (230 beds) located there. Contact Robert G. Young, M.D., Secretary, Grant County Medical Society, 1207 Northwood Court, Marion, 46952.

Hamilton — NOBLESVILLE — population 7,600. Located 25 miles north of Indianapolis. County seat town with an 86-bed county hospital. Contact Haldon C. Kraft, M.D., 195 S. 10th St., Noblesville, 46060.

Knox — VINCENNES — population 18,000. Located in southwestern Indiana; has a 227-bed hospital. Contact E. R. Cantwell, M.D., 202 Broadway Street, Vincennes, 47591.

St. Joseph — SOUTH BEND — population 132,445. For details contact Mr. Harry Davis, Executive Secretary, St. Joseph County Medical Society, 106 W. Monroe St., South Bend, 46601.

INTERNAL MEDICINE

Delaware-Blackford — MUNCIE — population 70,000. Opening at Muncie Clinic. Ball State University located there — 12,000 students. Ball Memorial Hospital — 450 beds and 150-bed addition now under construction. Contact Mr. Pence, Manager, Muncie Clinic, 420 W. Washington St., Muncie, 47305.

Howard — KOKOMO — population 50,000. Two hospitals. Opening for internist with a four-man group operating out of a new 18-room clinic soon to be enlarged. Contact Mr. Robert E. Thompson, Business Manager, 401 E. Reynolds Dr., Kokomo, 46902.

Huntington — HUNTINGTON — population 16,185. A well equipped office and a busy practice is available because of the sudden death of Dr. Joseph Clark. County hospital — 100 beds. Contact Wayne S. Miller, M.D., 610 N. Jefferson St., Huntington, 46750.

Kosciusko — WARSAW — population 7,200 with a three mile radius population of 12,000. Located in the Northern part of Indiana in the lake region; 68-bed hospital in the town. Contact Thomas Keough, M.D., 600 E. Winona Ave., or William Cron, M.D., 827 S. Union St., Warsaw, 46580.

Putnam — GREENCASTLE — population 8,500. Home of DePauw University. County seat town with a county hospital (79 beds). Contact J. B. Johnson, M.D., 105 E. Washington St., Greencastle, 46135.

St. Joseph — SOUTH BEND — population 132,445. Two hospitals. Located in northern Indiana. Contact Mr. Harry Davis, Executive Secretary, St. Joseph County Medical Society, 106 W. Monroe St., South Bend, 46601.

Wells — BLUFFTON — population 6,250. Opening for internist at the Caylor-Nickel Clinic, (164 beds). Contact W. E. Symon, M.D., Caylor-Nickel Clinic, 303 S. Main St., Bluffton, 46714.

NEUROLOGY

St. Joseph — SOUTH BEND — population 132,445. Contact Mr. Harry Davis, Executive Secretary, St. Joseph County Medical Society, 106 W. Monroe St., South Bend, 46601, for details.

OBSTETRICS and GYNECOLOGY

Knox — VINCENNES — population 18,000. Good Samaritan Hospital (227 beds) located there. For details contact Donald T. Bartlett, M.D., 307 S. Fifth St., Vincennes, 47591.

OPHTHALMOLOGY

Hamilton — NOBLESVILLE — population 7,600. Located 25 miles north of Indianapolis. County hospital (86 beds). For details contact Haldon C. Kraft, M.D., 195 S. 10th St., Noblesville, 46060.

Knox — VINCENNES — population 18,000. For details contact E. R. Cantwell, M.D., 202 Broadway St., Vincennes, 47591.

Putnam — GREENCASTLE — population 8,500. For further information contact J. B. Johnson, M.D., 105 E. Washington St., Greencastle, 46135.

St. Joseph — SOUTH BEND — population 132,445. Contact Mr. Harry Davis, Executive Secretary, St. Joseph County Medical Society, 106 W. Monroe St., South Bend, 46601.

ORTHOPEDICS

Grant — MARION — population 37,850. Contact Robert G. Young, M.D., Secretary, Grant County Medical Society, 1207 Northwood Court, Marion, 46952.

Hamilton — NOBLESVILLE — population 7,600. For details contact Haldon C. Kraft, 195 S. 10th St., Noblesville, 46060.

St. Joseph — SOUTH BEND — population 132,445. Two hospitals. For details contact Mr. Harry Davis, Executive Secretary, St. Joseph County Medical Society, 106 W. Monroe St., South Bend, 46601.

Wells — BLUFFTON — 6,250. For details contact W. E. Symon, M.D., Caylor-Nickel Clinic, 303 S. Main St., Bluffton, 46714.

PATHOLOGY

Howard — KOKOMO — population 50,000. Opening for an associate. Contact Max Rudicel, M.D., 1907 W. Sycamore St., Kokomo, 46902.

PEDIATRICS

Delaware-Blackford — MUNCIE — population 70,000. Opening for physicians specializing in pediatrics. 12,000 student Ball State University located in Muncie. Ball Memorial Hospital—450 beds and 150-bed addition now under construction. Contact Mr. Pence, Manager, Muncie Clinic, 420 W. Washington St., Muncie, 47305.

Grant — MARION — population 37,850. Contact Robert G. Young, M.D., Secretary, Grant County Medical Society, 1207 Northwood Court, Marion, 46952.

Knox — VINCENNES — population 18,000. For details contact Thomas Barrett, M.D., 307 S. Fifth St., Vincennes, 47591.

Putnam — GREENCASTLE — population 8,500. Pediatrician needed in Greencastle. Contact J. B. Johnson, M.D., 105 E. Washington St., Greencastle, 46135, for details.

St. Joseph — SOUTH BEND — population 132,445. Contact Mr. Harry Davis, Executive Secretary, St. Joseph County Medical Society, 106 W. Monroe St., South Bend, 46601.

Wells — BLUFFTON — population 6,250. Contact W. E. Symon, M.D., Caylor-Nickel Clinic, 303 S. Main St., Bluffton, 46714.

PSYCHIATRY

Howard — KOKOMO — population 50,000. Need for psychiatrist as soon as 20 to 25 psychiatric beds are added to hospitals. Contact Mr. George Banjak, Administrator, Howard Community Hospital, 3500 S. LaFountain St., Kokomo, 46902.

Jefferson-Switzerland — MADISON — population 10,500 — opening for four psychiatrists at Madison State Hospital (1,500 beds). Contact O. B. McAtee, M.D., Superintendent, Madison State Hospital, Madison, 47251.

St. Joseph — SOUTH BEND — population 132,445. Contact Mr. Harry Davis, Executive Secretary, St. Joseph County Medical Society, 106 W. Monroe St., South Bend, 46601, for details.

Wells — BLUFFTON — population 6,250. Contact W. E. Symon, M.D., Caylor-Nickel Clinic, 303 S. Main St., Bluffton, 46714.

SURGERY

Howard — KOKOMO — population 50,000. Two hospitals — Howard Community Hospital (100 beds) and St. Joseph Memorial Hospital (170 beds). Opening for a general surgeon with a four-man group operating out of new 18 room clinic soon to be enlarged. Contact Mr. Robert E. Thompson, Business Manager, 401 E. Reynolds Dr., Kokomo, 46902.

Knox — Vincennes — population 18,000. One hospital, Good Samaritan (227 beds). Contact E. R. Cantwell, M.D., 202 Broadway St., Vincennes, 47591.

UROLOGY

Knox — VINCENNES — population 18,000. Located in southwestern Indiana. Contact W. R. Vaughn, M.D., 615 Dubois St., Vincennes, 47591.

RADIOLOGY

Clay — BRAZIL — population 9,000 with a population of 15,000 within a five mile radius. County population 25,000. Located 15 miles from Terre Haute on U.S. 40. New county hospital. Contact Rahim Farid, M.D., 111 N. Walnut St., Brazil, 47834.

Wells — BLUFFTON — population 6,250. Contact W. E. Symon, M.D., Caylor-Nickel Clinic, 303 S. Main Street, Bluffton, 46714. ◄

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(see previous page)

The Journal
of the INDIANA STATE MEDICAL ASSOCIATION
Supervised by The COUNCIL
Volume 59 — August 1966 — Number 8

Combination Oral Antidiabetic Therapy With Acetohexamide (Dymelor*) And Phenformin (DBI)

JOSEPH I. GOODMAN, M.D.
Cleveland Heights, Ohio

THE AUTHOR [1,6-8] and others [2-5] have stated previously that the administration of phenformin (DBI) combined with any sulfonylurea drug is more effective in the treatment of diabetes than any of the drugs alone. In prescribing combined therapy, the author noted that acetohexamide and phenformin appeared to be unusually effective. Accordingly, the present study was designed to evaluate further the relative efficacy of these two drugs as compared with other combinations and with the various antidiabetic drugs used individually.

Materials and Methods

The patients selected for trial with acetohexamide (Dymelor) and phenformin (DBI) consisted solely of cases of secondary failure with hypoglycemic drugs prescribed individually or in combination. The patients were being treated by the author in private practice and in the Diabetes Outpatient Clinic of Mt. Sinai Hospital, Cleveland, Ohio.

The author considers the diabetes well regulated when the 24-hour urine collection, examined quantitatively (Somogyi method), contains less than 10 grams of glucose. The patient taking oral drugs is started on either tolbutamide (Orinase) or chlorpropamide (Diabinese). When the 24-hour excretion of glucose exceeds 10 grams consistently, the patient is given either larger doses of these drugs or phenformin is added. As a last resort, in the event of secondary failure on the other drugs or combinations of drugs, acetohexamide and phenformin is started and maintained as long as diabetic control is successful or until insulin is indicated.

The following combinations of acetohexamide and phenformin were utilized in these patients: acetohexamide, 1.0 Gm. + phenformin, 50 mg. (11 clinical trials); acetohexamide, 1.0 Gm. + phenformin-TD, 100 mg. (5 clinical trials); acetohexamide, 1.0 Gm. + phenformin-TD, 50 mg. (17 clinical trials); acetohexamide, 0.5 Gm. + phenformin-TD, 100 mg. (four clinical trials); acetohexamide 0.5 Gm. + phenformin-TD, 50 mg. (six clinical trials); acetohexamide 1.0 Gm. + phenformin-TD, placebo (two clinical trials).

There were 34 patients in this series to whom acetohexamide-phenformin combinations were given following secondary failure on other antidiabetic preparations. Of these, 21 were private patients and 13 were treated in the Diabetes Outpatient Clinic of Mt. Sinai Hospital. One of these patients proved to be a primary failure on acetohexamide-phenformin combinations as well as on other preparations. Each of the remaining patients was given more than one drug in various dosages in addition to the acetohexamide-phenformin combinations. In the 34 patients there were 45 clinical trials with one or more acetohexamide-phenformin combinations (Table 1), 22 clinical trials with other combinations and 122 clinical trials with individual drugs, chiefly tolbutamide, chlorpropamide and phenformin. In addition, there were five clinical trials with tolbutamide and chlorpropamide in combination.

In each patient the various drugs and combinations are compared as to their relative antidiabetic efficacy based on quantitative measurements of glucose in multiple 24-hour urine collections. These preparations are then ranked according to their antidiabetic action in each patient and tabulated as in Table 2. The highest possible rating is 1.0, ranging downward as low as seven in the case of carbutamide which was prescribed in one patient. The acetohexamide-phenformin combinations were taken for periods of at least six weeks to as long as 45 months.

Results

It can be seen in Table 2 that two acetohexamide-phenformin preparations (acetohexamide, 1.0 Gm. +

*Supported by Eli Lilly & Company, Indianapolis, Ind.

SUMMARY OF DATA

34 cases

21 private

13 OP. Dept.

	No. Clinical Trials
Acetohexamide-phenformin	45
Other combinations with phenformin	22
Trials with single drugs	122
Tolbutamide + chlorpropamide	5

1 primary failure

1 mild hypoglycemia

1 hospitalized with severe hypoglycemia on acetohexamide, 1.0 Gm. + phenformin, 50 mg., also on chlorpropamide-phenformin.

Side Effects:

1. Diarrhea and loss of stamina with acetohexamide-phenformin. No ill effects on acetohexamide alone.
2. Metallic taste with DBI-TD 150 mg.
3. Nausea with acetohexamide-phenformin. No ill effects on acetohexamide only.

TABLE 1

phenformin, 50 mg. and acetohexamide, 1.0 Gm. + phenformin-TD, 100 mg.), in 16 clinical trials, have the most efficacious antidiabetic action. The next three high-ranking preparations are also acetohexamide-phenformin combinations. The results of 43 clinical trials indicate that these preparations are superior to all the other hypoglycemic combinations.

In two patients, in whom placebos were substituted for DBI-TD, the effect is no greater than that of acetohexamide, chlorpropamide or tolbutamide alone (Table 2). Although the combinations of phenformin with chlorpropamide and tolbutamide rank somewhat below the acetohexamide-phenformin combinations, they also are more effective than the individual drugs or the combination of the two sulfonylureas—tolbutamide and chlorpropamide.

An assortment of drugs and combinations which were prescribed less than three times — a total of 19 clinical trials are listed in Table 3. These results round out the data in the 34

COMPARISON OF ANTIDIABETIC DRUGS IN COMBINATION AND UNCOMBINED

Name of Drugs		No. Cases	Efficiency Rating
Acetohexamide	1.0 Gm. + Phenformin-50 mg.	11	1.0
Acetohexamide	1.0 Gm. + Phenformin-TD-100 mg.	5	1.0
Acetohexamide	1.0 Gm. + Phenformin-TD-50 mg.	17	1.1
Acetohexamide	0.5 Gm. + Phenformin-TD-100 mg.	4	1.2
Acetohexamide	0.5 Gm. + Phenformin-TD-50 mg.	6	1.6
Chlorpropamide	0.5 Gm. + Phenformin-50 mg.	10	2.0
Tolbutamide	1.0 Gm. + Phenformin-50 mg.	4	3.2
Acetohexamide	1.0 Gm. + Phenformin-TD-placebo	2	3.5
Acetohexamide	2.0 Gm.	8	2.3
Chlorpropamide	250 mg.	4	2.5
Acetohexamide	1.0 Gm.	16	2.6
Chlorpropamide	0.75 Gm.	3	3.0
Acetohexamide	1.5 Gm.	9	3.2
Chlorpropamide	0.5 Gm.	9	3.4
Tolbutamide	2.0 Gm.	13	3.9
Tolbutamide	1.5 Gm.	20	4.1
Tolbutamide	1.0 Gm.	21	4.5
Tolbutamide	1.0 Gm. + Chlorpropamide 0.5 Gm.	5	4.5
Tolbutamide	0.5 Gm.	6	5.9

TABLE 2

ANTIDIABETIC DRUGS IN LESS THAN THREE CLINICAL TRIALS

		No. Clinical Trials	Efficiency Rank
Tolbutamide	1.0 Gm. + Phenformin-TD-100 mg.	1	1.0
Chlorpropamide	250 mg. + Phenformin-25 mg.	1	1.0
Chlorpropamide	0.5 Gm. + Phenformin-TD-100 mg.	1	1.0
Phenformin-TD	100 mg.	2	1.5
Chlorpropamide	0.5 Gm. + Phenformin-TD-50 mg.	1	2.0
Tolbutamide	1.0 Gm. + Phenformin-TD-50 mg.	1	2.0
Chlorpropamide	1.0 Gm.	2	2.0
Phenformin-TD	150 mg.	1	2.0
Phenformin-TD	50 mg.	2	2.5
Chlorpropamide	1.0 Gm.	2	2.5
Chlorpropamide	250 mg. + Phenformin-50 mg.	1	3.0
Phenformin	50 mg.	2	4.0
Tolinase	100 mg.	1	4.0
Carbutamide	1.0 Gm.	1	7.0

TABLE 3

patients not listed in Table 2 but are not statistically significant.

In 34 patients and 45 clinical trials with acetohexamide-phenformin combinations, there were only three instances of mild side effects (Table 1). In each case the ill effects were attributable to phenformin — diarrhea with loss of stamina, one case; metallic taste with DBI-TD, one case; nausea, one case. These symptoms disappeared promptly using a lower dose in one patient; the combination of drugs had to be discontinued in the remaining two patients, each of whom has felt perfectly well on acetohexamide alone. In addition, one patient experienced a severe episode of hypoglycemia and another had a mild attack. The former patient had had a similar episode with a chlorpropamide and phenformin combination.

Comment

The data obtained in the present study reaffirms the potency of combined oral antidiabetic drugs in cases of secondary failure as compared with the same preparations prescribed individually. Moreover, in 34 patients in whom acetohexamide-phenformin combinations were prescribed for secondary failure, their antidiabetic effects were decidedly superior (Table 2). In every instance (43 clinical trials) in which acetohexamide-phenformin preparations were used, they proved to be more efficacious than chlorpropamide-phenformin or tolbutamide-phenformin combinations. However, all the combinations were superior to any single sulfonylurea drug (acetohexamide, chlorpropamide and tolbutamide). The remaining clinical trials with hypoglycemic drugs and combinations (as shown in Table 2) were prescribed in only one or two clinical trials. Obviously no conclusions can be drawn from these scattered results.

Of 34 patients to whom acetohexamide-phenformin was given, there was only one case of primary failure in which insulin was required. Probably many others were able to avoid or postpone the use of insulin because of the effectiveness of the acetohexamide-phenformin combination. Despite the potency of this combination, there were only two instances of hypoglycemia — and one of these was mild. Still, it is advisable for patients using these combined drugs not only to maintain a normal food intake but, in addition, to take interval feedings containing either protein, fat, or both.

Three patients taking acetohexamide-phenformin experienced mild side effects — diarrhea, nausea and a metallic taste. These symptoms were attributable to phenformin and subsided promptly with discontinuance of the drug.

REFERENCES

1. Goodman, J. I.: Oral hypoglycemic agents in the treatment of diabetes, *Ohio Med. J.* 57:1245-1251, (Nov.), 1961.
2. Beaser, S. B.: Orally given combinations of drugs in diabetes mellitus therapy, *JAMA* 174:2137-2141, (Dec. 24), 1960.
3. Unger, R. H., Madison, L. L., Carter, N. W.: Tolbutamide-phenformin in ketoacidosis-resistant patients, *JAMA* 174:2132-2136, (Dec. 24), 1960.
4. Moss, J. M., Delawter, D. E., Gallagher, E. J.: Oral hypoglycemic drugs: comparative evaluation of tolbutamide, chlorpropamide, and phenformin, *Med. Times* 92:645-655, 1964.
5. Beaser, S. B.: Seven-year study of oral treatment of diabetes mellitus, (a scientific exhibit), AMA Annual Meeting, 1964.
6. Goodman, J. I.: Use of acetohexamide (Dymelor) in diabetic patients with secondary failures to antidiabetic drugs, *JISMA* 57:1133-1138, 1964.
7. Goodman, J. I.: Combination oral antidiabetic therapy: chlorpropamide (diabinese) and phenformin (DBI), *Ohio Med. J.* 61:982-984, (Nov.), 1965.
8. Goodman, J. I.: Phenformin (DBI) as an adjuvant in oral antidiabetic therapy, *Metabolism* 14:1153-1157 ,(Nov.), 1965. ◄

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Newer Concepts in the Therapy of Cardiogenic Shock

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THE MAJOR catastrophies following acute myocardial infarction are pulmonary edema, arrhythmias and shock. With the newer technics of monitoring, external cardiac massage and electric conversion of arrhythmias, the percentage of patients surviving infarction is steadily increasing. Appropriate therapy for pulmonary edema continues to result in a high percentage of survival, provided shock does not intervene. The purpose of this paper is to attempt to outline a rational and physiologic approach to the third member of this triad, shock, in hopes that its high mortality may also be reduced.

Disastrous, Fatal

Shock is a most disastrous and immediate event. It is the least common complication, occurring in only eight percent of myocardial infarctions. When it does occur, however, it is 80 to 95% fatal in the untreated patient. It is more common in the patient who was hypertensive prior to the infarction and becomes more life-threatening with advanced age.

The danger of shock decreases rapidly with time: 60% of the cases occur within 24 hours; over 90% within 72. Other guides to prognosis are: promptness of response to pressors, the presence or absence of arrhythmias and the concomitant onset of congestive failure. The latter is particularly unfortunate; there is a 60% mortality with failure and only 30% without it. Overall survival in patients treated with pressors is 50%.[1,2]

In order to approach cardiogenic shock rationally, the physiology of circulation needs to be reviewed. The major object of the treatment of shock is to restore tissue perfusion and thus maintain viability. Perfusion or flow depends upon total peripheral resistance (TPR) and blood pressure (BP). In the intact animal, flow becomes cardiac output (CO) and the relationship is expressed as BP = CO x TPR.

When cardiogenic shock is produced and studied in the intact animal, cardiac output is found to be reduced by 25 to 80% of normal. This is also true in the studies which have been done in man. In addition, there seem to be two distinct responses of TPR to cardiogenic shock. In the majority of cases, there is a rise in TPR, as one would expect, to maintain blood pressure. In about 15% of the animals, however, the TPR remains constant or even drops. The mediation for this paradoxical drop is unclear, but it appears to be mediated by vagal fibers which are not affected by atropine.[3]

Sympathomimetic Agents

One can raise the blood pressure of a patient with cardiogenic shock by increasing either cardiac output or TPR. Usually vasopressors are given and blood pressure is maintained at an arbitrary level. The agents in common use are either mixed alpha and beta stimulators (metaraminol, *Aramine;* norepinephrine, *Levophed)* or pure alpha stimulators (epinephrine, *Adrenalin;* phenylephrine, *Neo-Synephrine).*

Another potent vasopressor has been introduced recently, angiotensin II *(Hypertensin).* This agent is a pure and extremely potent vasopressor. It probably has no place in the treatment of cardiogenic shock. Angiotensin II reduces cardiac output and renal flow markedly, and there is evidence that it is a coronary artery vasoconstrictor.[4-6] It can be seen that the rise in blood pressure induced by these agents is mostly or entirely at the expense of tissue flow.

Students of shock have long been searching for methods of increasing tissue perfusion by increasing cardiac output. The first proposals were to increase venous return by transfusing the patient. This was not very appealing to the clinician because of the theoretical danger of inducing or worsening congestive failure. In 1949 Epstein and Relmon treated 30 patients in shock following myocardial infarction with whole blood.[7] The transfusions were made with arbitrary amounts of blood, and no attempts were made to measure central venous pressure. Comparing mortality to those not transfused, they noted no difference. It was noted, however, that patients in congestive failure, even with pulmonary edema, were not made worse by this treatment.

The latest and most promising agents for the treatment of cardiogenic shock are the beta stimulators.[8] After the humoral mediators of the sympathetic nervous system had been identified, attempts to explain their different actions resulted in the concept of alpha and beta receptor sites. The alpha sites are considered mostly constrictor and the beta, dilator. As this applies to the vascular system, the alpha sites are the vasoactive and venoactive sites. Thus, giving a pure alpha stimulator, e.g., norepinephrine, would increase the blood pressure only by increasing the TPR and decreasing tissue flow. It also would decrease venous return and reflexly, via the carotid body, decrease heart rate.

Beta stimulation, on the other hand, results in an increase in the strength of contractions of the heart (positive inotropic effect) and an increase in rate (positive chronotropic effect). Total peripheral resistance actually goes down while venous tone goes

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down. The net result is an increase in cardiac output and tissue perfusion. The blood pressure may go either up or down depending upon the balance between cardiac output and TPR.

A Definitive Diagnosis?

That blood pressure may go down has resulted in reluctance by the practicing physician to use beta stimulators. Dependence upon an arbitrary blood pressure value is deeply ingrained in the treatment of shock and giving an agent which may lower it is quite foreign to this concept. Only by accepting that the clinical determinants of skin turgor, ease of respiration and urine volume are more important than an absolute blood pressure reading can the beta stimulators be used and accepted. This is not a new concept; any discussion of shock is introduced by a discussion of the difficulty in defining it. One can recognize it quite easily, but define it with great difficulty. How frequently is the physician called hurriedly to a patient's bedside because of a low blood pressure reading, only to find the patient relaxed and comfortable.

Two beta stimulators are available for clinical use: isopropylnorepinephrine (Isuprel) and mephentermine (Wyamine). In an excellent study of cardiogenic shock using mephentermine, Bernstein had a 60% overall survival.[9] He was impressed by the increase in cardiac output and the rapid improvement in the patient clinically. Congestive failure will improve with the beta agents because their actions are similar to digitalis on the heart.

Interest in increasing blood volume in cardiogenic shock has been stimulated by the advent of central venous pressure (CVP) as a clinical determinant. In dog experiments, physiologists have noted for years that when shock is induced and then treated, the animal which receives excessive transfusions fares better. This introduced the concept of circulating volume versus effective volume. In the dog, the blood pools in the dilated splanchnic areas and is unavailable for perfusion. Although splanchnic pooling cannot be demonstrated in man, the concept of reduced effective blood volume is gaining acceptance. In the treatment of endotoxic shock, hypertransfusion has been used with success,[10] but it has not yet been tried on patients with cardiogenic shock since Epstein and Relmon's work.

Clinically the patient in shock should have a central venous pressure catheter introduced by cutdown from the cephalic vein. The catheter should be used for drawing blood samples, infusion of pressors and measurement of CVP. If, after pressor therapy is introduced, the CVP is high, then digitalization or phlebotomy would be indicated. If, on the other hand, the CVP is low, then attempts to increase the effective blood volume would be in order.

In the final analysis, the survival of the patient in shock depends upon the adequacy of tissue perfusion. As blood flow decreases, the capillary beds dilate in attempts to satisfy their metabolic needs. This increases flow and removes the metabolites. However, there is a limit to this mechanism past which flow decreases because the total capillary bed is too capacious for the blood volume.

Since the usual laminar flow of blood depends upon flow rate, there is a breakup of laminar flow and sludging as the flow rate decreases. Capillary sludging, in turn, further reduces flow and a cycle is established.[11]

Low viscosity dextrans (LVD) stabilize flow in the microcirculation by reestablishing laminar flow. The exact mechanism is unclear, but it is probably by coating the red cells with like charges and thus causing them to repel each other. Besides decreasing sludging, LVD also remains in the vascular space increasing the effective circulating volume. Finally, LVD is excreted in the urine unchanged, acting as an osmotic diuretic.[11] These attributes make LVD an ideal substance to be used in shock and many studies are now underway to determine its place in therapy.

Summary

1. Cardiogenic shock is an immediate and life-threatening complication of myocardial infarction. Untreated it is almost universally fatal.
2. Effective treatment has already reduced this mortality to less than 50%.
3. The rationale behind beta stimulators is described.
4. Central venous catheterization with monitoring of CVP is recommended.
5. Transfusion with low viscosity dextran is discussed.

BIBLIOGRAPHY

1. Nielsen, B. L., Marner, I. L.: Shock in Acute Myocardial Infarction, *Acta Med. Scand.* 175:65, 1964.
2. Heyer, H. E.: A Clinical Study of Shock Occurring During Acute Myocardial Infarction. An Analysis of 58 Cases, *Am. Heart J.* 62:437, 1961.
3. Costantin, LeRoy: Extracardiac Factors Contributing to Hypotension During Coronary Occlusion, *Am. J. Cardiol.* 11:205, 1963.
4. Udhoji, U. N., Weil, M. H.: Circulatory Effects of Angiotensin, Levarterinol, and Metaraminal in the Treatment of Shock, *New Eng. J. Med.* 270:501, 1964.
5. Smulyan, H., Cuddy, R. P., Eich, R. H.: Hemodynamic Effects of Pressor Agents in Septic Shock and Myocardial Infarction Shock, *JAMA* 190:188, 1964.
6. Miller, A. J., Kaplan, B. M.: The Therapy of Cardiogenic Shock, *Ann. Int. Med.* 58:901, 1963.
7. Epstein, F. H., Relmon, A. S.: Transfusion Treatment of Shock Due to Myocardial Infarction, *New Eng. J. Med.* 241:889, 1949.
8. Aviado, D. M.: Pharmacologic Approach to the Treatment of Shock, *Ann. Int. Med.* 62:1050, 1965.
9. Bernstein, A., et al.: Treatment of Shock in Myocardial Infarction, *Am. J. Cardiol.* 9:74, 1962.
10. Lillhei, R. C., et al.: The Modern Treatment of Shock Based on Physiologic Principle, *Clin. Pharm. and Thera.* 5:63, 1964.
11. Symposium on Shock, *Am. J. Surg.*, Vol. 110, No. 3, 1965.

Fluphenazine for the Treatment of Patients with Anxiety

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DURING the last decade, a change has evolved in the treatment of anxiety. Before the tranquilizing drugs were available, anxiety states were treated primarily by reassurance and the use of sedative agents. The introduction of the tranquilizers, however, has provided the physician with therapeutic agents that will effectively relieve anxiety and control its psychosomatic manifestations with relatively little sedative effect and without intellectual impairment.[1,2] That such agents fill an essential need in medical practice is evident by their widespread acceptance and use by physicians. More than 40 different drugs are now being recommended and used as tranquilizers.[2] In fact, the number of tranquilizing agents now available offers so many choices to the physician that he may have difficulty deciding which one is best for a particular patient.

A relatively new tranquilizing agent, fluphenazine, has proved effective for treating psychotic and severely disturbed mental patients.[3-5] More recent investigations have shown it to be effective also for treating patients with anxiety and tension of varying degrees of severity in general office practice.[6] Also, fluphenazine in small doses effectively controls symptoms of anxiety without altering the patients' judgment, mental acuity or behavior.[6,9-11] Fluphenazine differs from other phenothiazines in that it decreases apathy, inertia and fatigue, which so commonly accompany states of anxiety and tension.[12]

Fluphenazine is a phenothiazine derivative of the piperazine group.[7] Its tranquilizing properties are similar to those of other members of this group, but fluphenazine has greater potency and more prolonged duration of action.[8] This paper reports the results of a trial of fluphenazine in the treatment of patients with anxiety-tension states who were seen in daily medical practice. Most of these patients were suffering from physical illnesses in addition to anxiety.

Materials and Methods

A total of 24 patients was treated with fluphenazine during the course of this study. Of these, two were males and 22 were females. Ages ranged from 36 to 88 years as shown below:

Age Range	Male	Female	Total
36-39	—	2	2
40-49	—	6	6
50-59	—	6	6
60-69	2	3	5
70-79	—	2	2
80-89	—	3	3
TOTALS	2	22	24

During the initial visit all patients complained of symptoms that are commonly associated with anxiety states. Over half the patients complained of tension, irritability, apprehension, insomnia, fatigue and headache. Other symptoms given by these patients included depression, excessive drowsiness, panic, phobias, anorexia, overeating, inability to concentrate, impaired memory, nightmares, palpitations and sweating. A number of the patients exhibited evidence of dissociative reactions, decreased or excessive motor activity, tremors, vasomotor disturbances and various gastrointestinal disorders. Symptoms were severe in three patients, moderate in 10 and mild in 11. Duration of symptoms varied from three weeks to three years.

Eighteen of the 24 patients had one or more physical disorders which might have contributed to their states of anxiety. Among these conditions were arteriosclerosis in two patients; hypertension in four; hiatus hernia in three; gastritis or gastric ulcer in two; and obesity, fracture of the spine, lordosis with persistent back pain, arthritis, nephritis, non-malignant brain tumor and chronic asthma, in one patient each. Diabetes mellitus was also present in two of the four patients with hypertension. Gastritis or acute pyelonephritis was also found in each of the three patients with hiatus hernia. Two of the 18 patients had previously experienced cerebrovascular accidents.

Of the remaining six patients of the series, two had a history of chronic alcoholism, one presented manifestations of schizophrenia, one exhibited symptoms of severe hypochondriasis, one complained of recurrent migraine headaches and one patient was apprehensive and tense, apparently because of an impending divorce from her husband.

Seven of the 24 patients under study had not had previous treatment for anxiety. Thirteen patients had received treatment with other phenothiazines or tranquilizing agents. These included promazine, chlorpromazine, perphenazine, trifluoperazine and thioridazine; as well as chlordiazepoxide, meprobamate alone or meprobamate with tridihexethyl chloride or promazine, chlorprothixene, chlorphenoxamine and phenylaglycodol. An additional four patients of the series had been under previous treatment with barbiturates or other sedatives. The therapeutic results with these agents were unsatisfactory in every case. Some patients showed no response at all while others experienced a worsening of their original symptoms or the appearance of side effects such as drowsiness, agitation, confusion, nausea and anorexia, parkinsonian reactions, rashes and excessive sweating. Prior to this clinical trial, none of the patients had ever re-

ceived fluphenazine.

Medication

Fluphenazine* was administered to each of the 24 patients for relief of anxiety, as tablets containing 1 mg. or 2.5 mg. of the drug. Initial doses ranged from 1 mg. to 4 mg. daily. At the time of the second visit, the dosage was adjusted, when indicated, according to the clinical response of the patient. Initial doses were maintained for 15 patients throughout the study. Doses were increased from 1 mg. to 2 mg. for two patients. Doses were reduced from 2 mg. to 1 mg. for three patients, from 2.5 mg. to 1 mg. for another, from 2.5 to 2 mg. for another patient, and from 4 mg. to 1 mg. and 2 mg., respectively, for two additional patients. Further adjustments of dosage were made for four of these patients, always within a range of 1 to 2.5 mg. daily. Patients were seen usually at monthly intervals during the study.

At the time treatment with fluphenazine was begun, three of the patients in the series were under treatment with other medications and in each instance such treatment was continued. The concomitant medications were triamcinolone in one patient with nephritis, a combined preparation of *Rauwolfia serpentina* and bendroflumethiazide with potassium supplement in another patient with hypertension, and bendroflumethiazide with potassium supplement in the one obese patient of the series. At the time of writing, treatment with fluphenazine had been continued in the individual patients for periods ranging from one to five months.

Results

Table I shows the clinical responses of the patients of this series to treatment with fluphenazine in relation to the relative degree of severity of their illnesses. Table II summarizes the results observed according to the dosages in which the drug was initially administered.

*Supplied as Prolixin® by E. R. Squibb & Sons, New York, New York.

CLINICAL RESPONSES IN 24 PATIENTS WITH ANXIETY AND TENSION TO TREATMENT WITH FLUPHENAZINE

Initial Status of Patients' Illness	No. of Patients			Clinical Responses*		
	Male	Female	Total	Satisfactory	Unsatisfactory	Not Evaluated
Severe	–	3	3	2	1	–
Moderate	1	9	10	9	–	1
Mild	1	10	11	11	–	–
TOTALS	2	22	24	22	1	1

*A *satisfactory* response: complete relief or diminution of symptoms so that they were no longer disabling.

An *unsatisfactory* response: no relief of symptoms during first three months of treatment.

TABLE I

As can be seen from Table I, satisfactory responses were observed in 22 (92%) of the 24 patients and an unsatisfactory response was evident in one. The response in the remaining patient was not evaluated. All of the patients with mild anxiety responded satisfactorily to treatment with fluphenazine. Nine of the 10 patients with moderate anxiety responded satisfactorily; two of the three patients with severe anxiety showed satisfactory responses. Satisfactory responses were manifested by complete or almost complete relief of symptoms so that they were no longer disabling. The one patient who did not respond satisfactorily showed no improvement during the first three months of treatment, after which time some symptoms were relieved.

It is evident from Table II that improvement occurred in most patients at all dosage levels. Both of the patients started on 1 mg. daily improved; 16 of the 18 patients initially placed on 2

DOSAGES OF FLUPHENAZINE USED AND THE OBSERVED RESULTS

Initial Dosage of Fluphenazine* (mg./day)	No. of Patients	Results		
		Improved	Unimproved	Not Evaluated
1	2	2	–	–
2	18	16	1	1
2.5	2	2	–	–
4	2	2	–	–
TOTALS	24	22	1	1

*Initial doses were maintained throughout for 15 of the 24 patients: adjustments in dosage were made in 9 patients as follows:

For two patients on 1 mg. daily: the dose was increased to 2 mg. then decreased to 1 mg. for one; it was increased to 2 mg. for the other.

For three patients on 2 mg. daily: the dose was reduced to 1 mg. in two; it was decreased to 1 mg. then increased to 2.5 mg. daily for the other.

For the two patients on 2.5 mg. daily: the dose was decreased to 1 mg. daily in one; it was decreased to 2 mg. daily then increased to 2.5 mg. daily but finally reduced to 1 mg. a day in the other.

For two patients on 4 mg. (2 mg. b.i.d.): the dose was reduced to 2 mg. once daily in one patient; and it was lowered to 2 mg. and then to 1 mg. once daily in the other.

TABLE II

ONSET OF CLINICAL RESPONSE AT DIFFERENT INITIAL DOSAGE LEVELS*

	Onset of Clinical Response in 24 Patients				
Daily Initial Dose	1-2 Days	3-5 Days	6-10 Days	Undetermined	Total
1 mg.	–	–	–	2	2
2 mg.	–	10†	2	6**	18
2.5 mg.	–	2	–	–	2
4 mg.	1	–	–	1	2
TOTALS	1	12	2	9	24

*Initial doses were subsequently adjusted in 9 patients.

†Onset of clinical response was noted in one patient between three and six days after start of therapy.

**One of these patients showed no improvement during the first three months of therapy though some symptoms subsequently were relieved.

TABLE III

mg. daily improved; the two patients started on 2.5 mg. daily improved; and both the patients on 4 mg. daily improved. Of the nine patients whose dosages were adjusted, all exhibited satisfactory responses to treatment. The one patient of the series who did not respond satisfactorily was a schizophrenic with severe symptoms and a history of failure to respond to previous therapy with other drugs. The remaining patient, whose response was not evaluated, did show some reduction in her anxiety after two months of therapy with fluphenazine.

Onset of Clinical Responses

The onset of clinical response at the various dosage levels employed in the study is shown in Table III. It is evident from this table that both patients who were started on 1 mg. daily responded within an undetermined period after treatment was begun. Of the 18 patients placed initially on 2 mg. daily, 10 responded within three to five days, two improved within six to 10 days, and five experienced some relief of symptoms within an undetermined period after the start of therapy. The remaining patient who was started on 2 mg. showed no improvement during the first three months of therapy, although some symptoms were subsequently relieved. The two patients who began treatment on 2.5 mg. daily showed initial improvement on the third to fifth day of therapy. Improvement was evident within one to two days in one of the two patients started on 4 mg. daily. The onset of response in the other patient on 4 mg. daily was not determined.

Side Effects

Side effects were reported by 18 of the 24 patients, as shown in Table IV, with 13 of the 18 patients reporting more than one reaction. Insomnia and extrapyramidal effects (muscle tenseness or spasm, parkinsonism, akathisia and dyskinesia) were the most common; both were reported by eight patients. An additional five patients reported nausea and four complained of headaches. Vomiting, pruritus, rash and dizziness each developed in three patients. and anorexia was experienced by two patients during treatment with fluphenazine. Postural hypotension was reported by one patient. In no case was it necessary to discontinue treatment because of side effects; in only one case was the dosage reduced because of side effects. In the latter instance, the dose of fluphenazine was reduced from 2 mg. to 1 mg. because of the patient's complaint of nausea. With the exception of moderately severe muscle tenseness in one patient, of moderately severe dizziness and insomnia in another, and of mild insomnia that persisted for three to 10 days in three other patients, all side effects were mild and transient.

SIDE EFFECTS REPORTED BY 18 PATIENTS

Side Effect	No. of Patients*
Insomnia	8
Muscle tenseness or spasm	5
Nausea	5
Excessive drowsiness	4
Headache	4
Vomiting	3
Pruritus	3
Rash	3
Dizziness	3
Anorexia	2
Parkinsonism	1
Akathisia	1
Dyskinesia	1
Postural Hypotension	1

*More than one side effect was reported by 13 of the 18 patients.

TABLE IV

Comment

The results of this study confirm the findings of other investigators that fluphenazine is an effective drug in doses of 1 to 4 mg. daily for the treatment of patients with symptoms of anxiety.[6,9,13] The findings in this study also demonstrate that the greatest percentage of patients who improved were those who had mild or moderate symptoms, though two out of the three severely ill patients obtained satisfactory relief of symptoms. The one patient of the series who failed to respond satisfactorily had schizophrenia, was severely depressed and apprehensive; perhaps a better response would have resulted in her case with a dose of fluphenazine higher than 2 mg. daily.

It was evident that in this series the onset of clinical response to treatment with fluphenazine occurred in more than half of the patients within three to five days after treatment was started. It was also evident that most of the patients responding within this period were receiving a dosage of 2 mg. daily. Although this series is too small to permit definitive conclusions, the findings would indicate that 2 mg. daily is an adequate dose to induce prompt relief of symptoms of anxiety in most patients, although a higher dosage seemed to induce a faster response in one of the patients.

Summary and Conclusions

A total of 24 patients with symptoms of anxiety and tension of varying degrees of intensity was treated with fluphenazine in doses of 1 to 4 mg. daily for periods of one to five months. Twenty-two of the 24 patients showed satisfactory responses to treatment with complete or almost complete relief of symptoms. All patients with mild anxiety improved; nine of the 10 moderately ill patients also improved; and two of the three severely ill patients obtained satisfactory relief of symptoms. One patient showed an unsatisfactory response to treatment. The therapeutic results were not evaluated in another patient.

Side effects were reported by 18 patients but these were generally mild and transient. In no case was treatment discontinued because of side effects. Insomnia and extrapyramidal effects were the most commonly observed effects, although nausea, excessive drowsiness, headache, vomiting, pruritus, rash, dizziness, postural hypotension and anorexia were also reported. The dose was reduced in one patient because of nausea.

Fluphenazine is an effective agent for relief of symptoms of anxiety and tension in daily doses of 1 to 4 mg.

REFERENCES

1. Himwich, H. E.: Psychoactive drugs, *Postgrad. Med.* 37:35, 1965.
2. Friend, D. G.: Sedatives and tranquilizers in general medical practice. In Modell, W.: *Drugs of Choice, 1964-1965*, C. V. Mosby, St. Louis, 1964, pp. 266-267.
3. Taylor, I. J.: Clinical evaluation of a new fluorinated phenothiazine neuroleptic, fluphenazine, *Dis. Nerv. Sys.* 21:169, 1960.
4. Deom, P., Buxbaum, H., Gatski, R. L.: Experience with fluphenazine in a psychiatric hospital, *Dis. Nerv. Sys.* 23:231, 1962.
5. Strang, W. C., French, R.: Use of fluphenazine in an acute and intensive treatment center, *Current Ther. Res. 4 (Suppl.)* :218, 1962.
6. Kossover, M. R., Goldman, A. M.: Clinical experience with fluphenazine (Prolixin) A new phenothiazine drug, *J. Louisiana State M. Soc.* 113:516, 1961.
7. Ayd, F. J., Jr.: Current status of major tranquilizers, *J. Med. Soc. New Jersey* 57:4, 1960.
8. High, J. P., Hassert, G. L., Jr., Rubin, B., Piala, J. J., Burke, J. C., Craver, B. N.: Pharmacology of fluphenazine (Prolixin), *Toxicol. & Applied Pharmacol.* 2:540, 1960.
9. Proctor, R. C.: Results with fluphenazine in anxiety and tension, *Dis. Nerv. Sys.* 21:283, 1960.
10. Carsley, S. H., Olson, J. A.: Use of fluphenazine dihydrochloride for relief of anxiety, *Clin. Med.* 69:717, 1961.
11. Ernst, E. M.: Clinical study of fluphenazine in general practice, *Clin. Med.* 7:1349, 1960.
12. Ayd, F. J., Jr.: Fluphenazine: Its spectrum of therapeutic application and clinical results in psychiatric patients, *Current Therap. Res.* 1:41, 1959.
13. Batterman, R. C., Mouratoff, G. J., Kaufman, J. E.: Comparative treatment of the psychoneurotic reactive-type anxiety state with fluphenazine and chlordiazepoxide, *J. New Drugs* 3:297, 1963. ◄

5839 E. Washington St.
Indianapolis

From *The Journal* 50 Years Ago

Physicians of Columbus, Ind., have no office hours after 6 p.m. during July and August.

* * *

According to the ruling of the State Board of Health made on July 7, the public drinking cup is positively abolished after August 1. Special instructions have been sent to health authorities and officials all over the state.

* * *

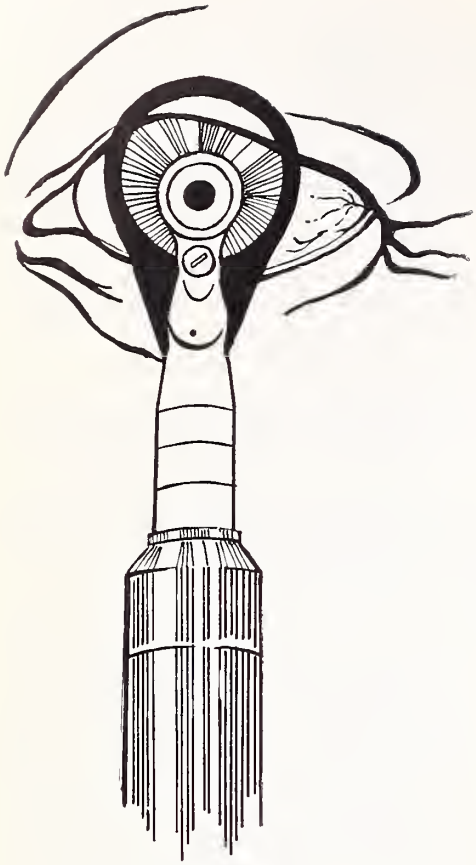
Mercurialized serum represents an important advance in the administration of mercury for the treatment of cerebral and systemic syphilis. To supply the demand for mercurialized serum, the H. K. Mulford Company is furnishing mercurialized serum in sealed ampoules which may be obtained in varying doses to be used for either the intra-spinal or intravenous treatment.

* * *

The physicians of Hancock County have adopted a fee bill and are establishing a list of persons deemed to be unworthy of credit as a result of failure to pay for medical or surgical attention when able to do so.. Those signing the bill agree to enter into no contract of any kind whatsoever to do lodge or other corporation practice except at the minimum fees in the fee bill as adopted.

* * *

The fourth annual convention of the Cremation Association of America will be held in the auditorium of the Hotel Gibson, Cincinnati, Thursday and Friday, August 24 and 25. All those who believe in or are interested in cremation are cordially invited to attend.—News Notes, *JISMA*, August, 1916.



The Case of the Helical Haloes

ARNOLD LIEBERMAN, M.D.
New York, N. Y.

UST beyond memory, practitioners of the healing arts were favorite objects of derision. Incompetence and quackery were almost the least of the failings lampooned by such artists as Hogarth, Goya and Daumier. Twentieth century science did much to swing the pendulum of public opinion over to a glorification of the doctor of medicine. (This may flatter our egos even if we know that it is our fellow M.D.'s who are in the best position to make a judgment as to our skills.) Still, it is the public that holds the purse strings; it is the majority consensus that determines which doctor is successful and which is not. As to the *basis* for any given lay person's opinion??

That is what launches me into the tale of Miguel Nubloso-Ojo. The regular ship surgeon was away; I was having a spur of the moment, paid vacation as his substitute on a Caribbean cruise. Miguel came to me during sick-call hours for the crew. He was a very quiet, seemingly very intelligent Spaniard who spoke excellent English. His trouble was serious enough. For the last couple of days, his right eyeball had been aching. That very morning he had begun to see rings of lights "whirling around and around" whenever he would look at a light bulb. Also, vision had begun to dim in the right eye. He had been very healthy all of his life even if his teeth had begun to bother him. Just the day before leaving port, an abscessed right upper molar had been extracted.

Helical Haloes

The eyeball was almost rock hard. The pupil was round; if anything, it was slightly contracted. It did not respond to light. The orifice was steamy white; the ophthalmoscope could not penetrate beyond the cornea.

Ever since my student days, teachers in ophthalmology had warned us about the *helical haloes* — the whirling rings of light that are diagnostic of that dread destroyer of vision, blinding *glaucoma*.*

**Primary* glaucoma may be of the acute or chronic congestive, narrow angle type; it may also be a chronic, simple, wide angle type. Anatomically, the iris seems to get in the way; physiologically, for reasons still not fully elucidated, more aqueous begins to form than can escape via the canal of Schlemm. It is this excess that raises the intraocular pressure and sets in motion the physical events culminating in compression atrophy of the ophthalmic nerve.

Secondary glaucoma is usually the consequence of inflammatory, intraocular disease obstructing aqueous humor drainage. *Exudates* are produced by iritis, choroiditis, uveitis, etc. Here, treatment is directed at the underlying condition.

On shore, the patient would have been referred to an oculist: stat, immediately. Here — on the high seas — it was up to me to save his eyesight, pronto! Fortunately, some pilocarpine and neo-cortef were available. The man was put into his bunk; ice packs were applied over the eyes. In addition, Miguel received Diamox® and Tetracyn® even if I was uncertain as to a real necessity for them. At my request, the captain wired ahead to Cartagena to arrange for a consultation on our arrival the next day, a Sunday.

Overnight, Miguel showed definite improvement. The eyeball was much softer; the pain was gone. The pupil was still clouded but the haloes no longer "whirled around." We docked at 8 a.m.; a car was to pick us up by 10 a.m.. We were to drive to the harbor dispensary where the oculist was awaiting our arrival. By eleven: still no car so Miguel and I trudged over to the place. It was only a mile away but "The vertical rays of the tropical sun" (sometimes written out as one word) left me wringing wet and near heat exhaustion by the time we — finally — got there.

A Liquescent Lipophiliac

It was shady and much cooler inside even if the floors were littered and the general decor — and decorum — left much to be desired. Miguel's English was good, his native Spanish, impeccable. Soon, we were directed to el medico oculisto, Jorge Rodriguez y something or other. The gentleman was very sportily attired in bright (grease-spotted) Bermuda shorts held loosely by a straining belt around an extremely ample girth. A greying, sweat stained, sport shirt and sneakers sans socks made up the scanty ensemble. The face was wreathed by a cordial smile exposing tobacco stained teeth. His unshaven chin and cheeks were redeemed by twinkling eyes.

With one hand he was mopping his brow with a large, hospital towel; with the other, he was taking generous swigs of rum spiked fruit juice from a

huge ice-filled mug. The bottle of liquor, all but empty, sat on the tray that also held a thermos jug with some ice cubes and a dish of candied nuts. The specialisto boomed a baritone bray of greeting to his Senor Colega (me) even as he arose and extended a pudgy hand of welcome. There were dirty mourning bands under his fingernails and his hairy paw was wet with perspiration. I suppressed my grimace of distaste and accepted gingerly the handshake; the generously proffered rum I declined firmly. Miguel was less fussy: he uptilted the bottle and gurgled it down to the end.

Our slightly *shicker* (tipsy) host led us briskly in search of an unoccupied examining room. Then the question of instruments arose as he had taken along none of his own. Batteries and bulbs corrode all too readily in the steaming heat; the ophthalmoscope I had taken along was operational; nothing at the dispensary was. Several functionaries were called and went into a voluble huddle with my eminent colleague. The upshot of the wrangle was a decision to proceed to his office. Miguel squeezed into the back seat of the doctor's little Austin; I climbed into the space next to the driver. Two bottles (one of rum, the other of plum brandy) nestled snugly between us.

The old quarter of Cartagena deserves a chapter all to itself. Picturesque it is! Also, the very first sewer system was in the process of being installed; for the first four centuries plus of its existence, the city had been content in the use of "storm canals". . . . We entered the three story building by removing laboriously heavy locks on successively barred, massive, solid steel doors. We passed a beauty salon on the first floor; then we unbarred more portals as we climbed flights of stairs unto a balcony surrounding a patio piled high with malodorous refuse and miscellaneous debris. The final barrier bore the doctor's name plate.

The office was small but well lighted and in reasonable order. A modest shelf of books (all of 1949 vintage and earlier) and a case full of special medicaments (mostly samples) flanked the medical diploma displayed on the wall. Miguel was seated while some pontocaine drops were put into both eyes. Shortly thereafter, he was ordered to lie flat on the examining table with his head hanging over the edge while eye tensions were taken. The tonometer read only 18 for the affected eye and 16 in the other. The Lord had been good to Miguel: the glaucomatous pressure had disappeared practically overnight!

"Ah, a cataract only!" The el medico oculisto sat down at his desk and wrote the diagnosis down on a bit of his stationery. I saw no slit lamp in that office. Did I waste half a day to be told such arrant nonsense?

Ingravescent Imbibition

As we were driven back to the harbor, I kept my silence. Miguel and the doctor socialized with the bottle of brandy; the 20-minute ride drained it dry as they chatted amiably in Spanish. It may have been rude of me to decline — yet again — any participation; frankly, I was too annoyed to care. Within minutes, a real-life shocker was to drive all things medical from my thoughts.

We had just entered the harbor area through the main gate. A group of custom guards were pummeling with their truncheons three young dock workers. It was about three of a Sunday afternoon; many hundreds of people were about. Suddenly, one of the teen-agers wrenched himself loose from his tormentors and started to run. A revolver shot rang out; the cargadore sprawled prone in the dust: dead! The aduano came up to the body and kicked it a couple of times even as he was holstering the weapon.

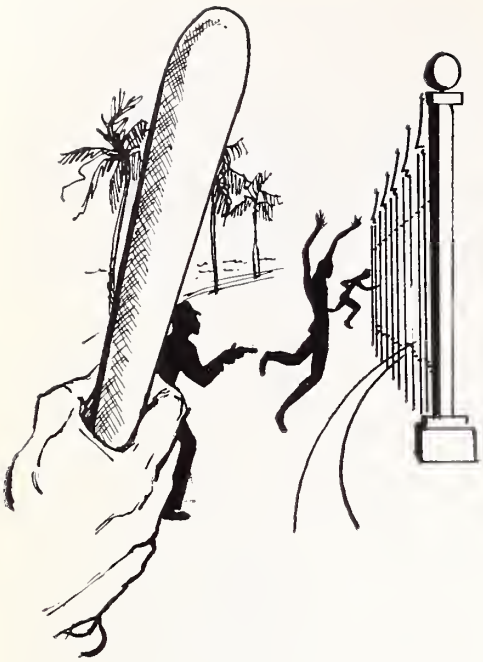
Stunned as I was, I could only gape. Anyway, the three stripes on my American uniform inhibited *any* action on my part. I was a *damn yanqui;* it was none of my business.

Even as Miguel translated, the calm oculisto explained the mise-en-scene. In that part of the Caribbean, there has been developed a device for circumventing ponderous legalities. Habitual lawbreakers are provoked by various means into trying to make a break to escape. The law of escape, *Leya de Fuga,* is invoked; the fleeing prisoner is shot on the spot. Thus, cumbersome, expensive trials are avoided; there is no further trouble with this particular criminal; an example has been set. The "execution" has to be as public as possible so as to convey the maximum deterrence from the warning.*

It was a *very* subdued ship surgeon who reported to his captain the gist of the afternoon's doings. My superior officer was briskly practical, "You tell me that our man is much better; tomorrow night we sail for Aruba. The Dutch are tops in everything they do. You'll take Miguel to a real eye specialist on Wednesday; he'll tell you what is what."

And so it proved. Oranjestad is a Dutch garden set on a desert Caribbean island. The mammoth oil refineries are Aruba's economic mainstay; the grimy soot of America's oil towns such as Whiting, Ind. and Bayonne, N.J. just isn't!

*Just recently, I read in the esteemed *New York Times* a factual article on the "Rurales," the Colombia-wide special trooper unit that has been set up solely for the purpose of stamping out rural guerrillas. Under their one-armed commander, they have revived the old-time KKK tradition of vigilante lynching. As a rather naive adherent of Jefferson, I fail to see how this "Leya de Fuga" differs from the "Ordnung" as enforced by Hitler's SS, Stalin's GPU, Franco's Falangistas or — to go back in history — Genghis-Khan's Mongols and Nero's Pretorian Guard.



Mirada de Cristal Nublado

The scheduled auto met us exactly on time; precisely at three we were at the oogarzt's office. Dr. Hilger's quarters were immaculately clean; the yard was a bower of flowers. The waiting room was crowded but the secretary ushered us in immediately. The doctor rose from behind his desk to greet us most cordially even if with typical Dutch reserve. He was a rather tall man, athletically supple, slender-waisted and just verging on middle age. A head mirror partially obscured a receding hairline. From each side of a Grecian nose, keen gray eyes probed with rapid efficiency. The clean shaven cheeks were tanned with outdoor living. The white jacket was fresh; the crease of the trousers was impeccable; the shoes were just so.

The history was taken with maximal effectiveness. The oogarzt's Oxonian English was clipped precisely; his Spanish directed at Miguel was polished Castilian; the nurse received directions in fluent French. The diplomas gracing the walls attested to graduation from Leyden followed by specialty training in England and France. The patient was led to an adjoining room almost crowded with the latest and best ophthalmological equipment. The ophthalmoscopes — the tonometer — the slit lamp — the gonioscopic gadget — the passing minutes were utilized with quiet purposefulness. It was a positive pleasure to witness so masterful an example of flawless performance!

"Ah, there, Dr. L.! Look at these floating bodies; your patient must have had an iritis that clouded the aqueous and gave the *secondary* glaucoma!"

The slit lamp was so well focused that even I had no difficulty in seeing the diagnostic data. The brown iris was muddy-colored; there was fibrin in the anterior chamber; the floating pus cells glistened in the intense light. The exudate filling the pupil was beginning to clear; the lens had not been affected.

Dr. Hilger continued, "As you see, he had an infected tooth that may have spread the germs to the maxillary sinus. This is a more likely etiology than tbc., g.c., sarcoidosis and other, more esoteric items. The medications you gave him checked the acute glaucomatous process. The iritis could drag on for a long time — but we hope not!

"Fill these prescriptions; we are a small town but your driver will take you to an excellent pharmacy around the corner from the Aruba Trading Co. I believe that these medications will carry our friend until you get back to N.Y."

The allotted half hour had sufficed to give Miguel the highest caliber attention imaginable. As we were being bidden a courteous good-bye, the next patient was being ushered in.

On the homeward trip, I saw Miguel twice daily. His convalescence continued its steady, placid course. The antibiotic controlled the infection; the steroids held the inflammatory reaction to a minimum. As we were entering our home port, I congratulated the patient on his recovery, "Wasn't that eye doctor on Aruba marvelous?"

"Well, doctor! That Aruba man was awfully stuck up! I liked the Cartagena specialisto much more; *he* was muey simpatico! He even shared his personal bottle of brandy with me; yes, straight down the hatch as you say in New York. . . ."

Which brings me full circle to the very first introductory paragraph. The final answer may be as sudden and definitive as the aduano, the custom guard, holstering his smoking revolver. Undeniably, it is the *PUBLIC* that has the last word as to which doctor is successful and which is not: of course!

But as to what forms the *basis* of this or that opinion??

Quien sabe? ◄

1270 Fifth Ave.
New York, N.Y.

Apologia

The name of Dr. Clifford C. Taylor, Community Hospital, Indianapolis, was inadvertently omitted from the 1966 edition of The Roster.

Dr. Taylor has been a member of the Indiana State Medical Association for many years. We regret any embarrassment or inconvenience caused by this error.

Electrocardiogram
of the month

Presented as a regular feature of The JOURNAL, Electrocardiogram of the Month is a series of short talks on cardiovascular diagnosis and treatment, edited by the staff of the Krannert Heart Research Institute, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis.

Paroxysmal Atrial Tachycardia (PAT) with Block (7)
Effect of Potassium

CHARLES FISCH, M.D.
Indianapolis

THE tracing reproduced in Figure 1 is an example of PAT with block due to digitalis excess and the prompt response of the arrhythmia to potassium.

The control tracing (9:30) demonstrates classical PAT with a 2:1 AV block. The rate of the ectopic focus is 214 per minute and that of the ventricles 107. Fifteen minutes after start of infusion of a solution of 50 mEq of KCl in saline (9:45) at a rate slightly over 0.5 mEq/min., there is attempt at 1:1 conduction of what appears to be both the ectopic beats and probably sinus (SA) beats. The former is exemplified by the P preceding the fourth and seventh QRS. The attempts at SA rhythm with a prolonged P-R is demonstrated by the P wave preceding the second, eighth and ninth QRS. PAT with 2:1 block is still present (e.g. between fifth and sixth QRS).

After approximately 20 mEq of K was administered (10:00) the PAT was abolished and the rhythm is one of sinus tachycardia with a rate of 150 per min. The P-R is approximately 0.28 sec. After 45 mEq of K (10:40) the SA rate slowed to 115 with a P-R interval of 0.14 seconds.

From the clinical standpoint, provided the patient's status is satisfactory, there would be no need to treat the arrhythmias per se, but simply to discontinue the digitalis. From the hemodynamic standpoint, the patient may fare just as well with his PAT with block as he does with the SA rhythm for the ventricular rates are about the same (107 vs. 115). ◄

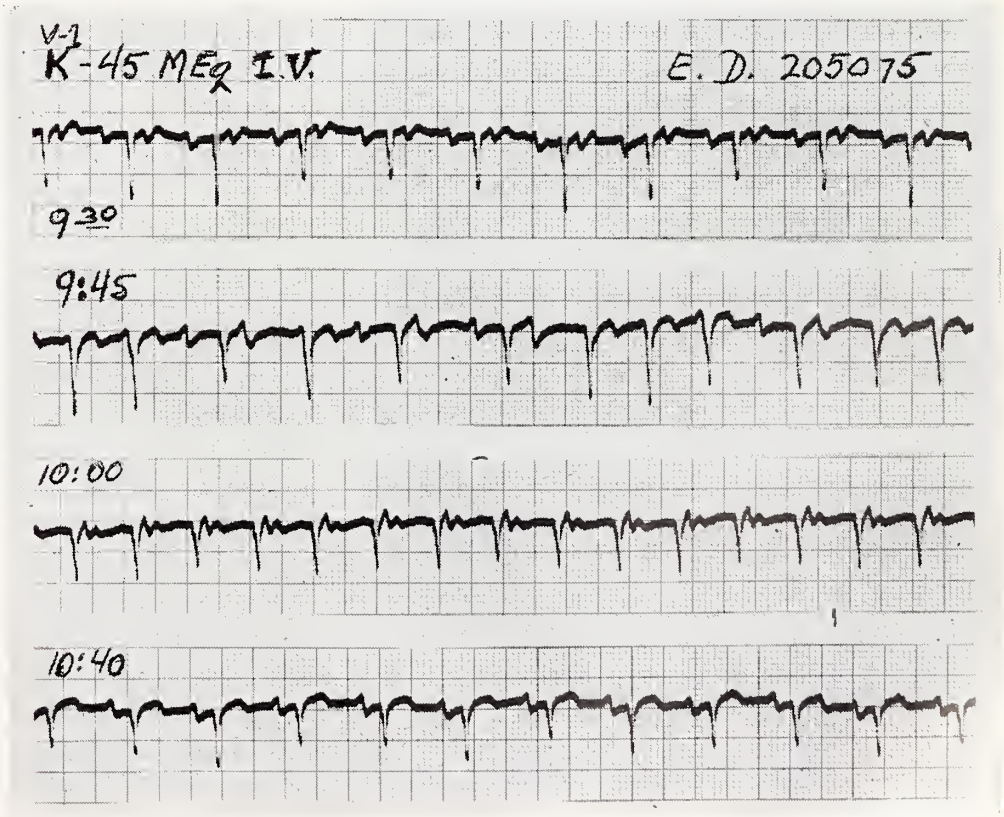


FIGURE 1

THE effect of intravenous potassium on PAT with block is demonstrated.

X-RAY CONFERENCE

Presented as a regular feature of *The Journal*, X-ray Conference is a series of short talks on procedure and radiologic diagnosis, edited by Erich K. Lang, M.D.

Ependymoma of the Fourth Ventricle

ERICH K. LANG, M.D.
Indianapolis *

A four-year-old white male was admitted to the hospital in a severely dehydrated condition. The pertinent history revealed disturbance of gait and ataxia developing during the past 12 weeks. The patient had complained of increasing headaches over the past four weeks. Finally, during the last three days, projectile vomiting developed and increasing drowsiness necessitated admission to the hospital. Physical examination showed some nuchal rigidity; the fundoscopic examination suggested increased intracranial pressure.

A skull roentgenogram revealed spreading of the lambdoid suture. In view of the history, the pertinent clinical and laboratory findings, a ventriculogram was performed (Figure 1). A huge space-occupying lesion, originating from the floor of the fourth ventricle was readily demonstrated. The mass filled the fourth ventricle almost completely. The right lateral recess of the fourth ventricle was obliterated; the left lateral recess was well demonstrated. Marked enlargement and dilatation of the fourth ventricle attested to the chronicity and relatively slow development of this mass lesion. On the basis of the age group, the intraventricular position originating from the floor of the fourth ventricle, and the history, a diagnosis of ependymoma was favored. Surgical exploration confirmed the presence of an ependymoma, which filled the fourth ventricle almost completely.

FIGURE 1

A huge mass fills the entire fourth ventricle, and appears to originate from the floor of this structure. The right lateral recess is obliterated, the left lateral recess is splayed but clearly delineated by air. The appearance of this huge intraventricular lesion is quite characteristic of an ependymoma.

Discussion

Posterior fossa lesions are frequently seen in the young child. The clinical history is usually distinguished by rapidity of onset of symptoms and progression of clinical manifestations. Pneumoencephalography is shuned because of the danger of herniating the cerebellar tonsils into the foramen magnum. Ventriculography with air or pantopaque as contrast media is favored. However, a reversed herniation of the brain-stem and the superior anterior cerebellar components through the free edge of the tentorium have been described and can result in fatal complications. The treatment of herniation of brain substance through either the foramen magnum or the free edge of the tentorium is accomplished by decompression of the posterior fossa via a needle introduced into the cis-

*Radiologist, Methodist Hospital, Indianapolis.

terna magna. Air, and particularly pantopaque, render a detail delineation of the posterior third ventricle, the aqueduct and the fourth ventricle. Lesions in these areas are readily amenable to examination by this technic. Arteriography, also a diagnostic study, is less seldom used in this age group. The technical difficulty of introducing a needle into the carotid or vertebral arteries in small children has curtailed the widespread use of this technic. Catheter arteriography may re-emphasize the value of this study.

The characteristic appearance of ependymomas of the fourth ventricle on pneumoencephalograms obtained in the AP projection emphasizes the diagnostic value of this examination. A markedly dilated fourth ventricle almost completely filled by an intraventricular mass originating from the floor of the fourth ventricle, with a lunate air shadow splayed above and around the mass, is considered highly suggestive of an ependymoma arising from the fourth ventricle floor. ◄

Pitfalls Facing the Medical Witness

The following items of advice for the physician testifying in a court of law were developed at an AMA Medicolegal Symposium.

1. *Do* take the role of the medical witness seriously. The courtroom is a place in which practical men are engaged in the serious work of endeavoring to administer justice. The role of the medical witness is a key one in this endeavor.

2. *Don't* agree to or accept compensation for your services contingent upon the outcome of the litigation. This practice is unethical and its disclosure would be apt to destroy the value of your testimony.

3. *Do* insist on preparation for your testimony in consultation with the attorney for the party who called you as a witness. He should advise you on what to expect on cross-examination. You have a right to consult with the party and his attorney about the case, so, don't be embarrassed if asked about such consultation.

4. *Don't* act as an advocate or partisan in the trial of the case. If the attorney for the party who calls you as a witness needs the advice or guidance of a doctor during the trial, let him employ another doctor. Disclosure of partisanship of a witness strongly tends to discredit his testimony.

5. *Do* be as thorough as is reasonably necessary under the circumstances in examining a party in preparation for trial. Exhaustion of all possible tests and procedures may not be required, but be prepared to justify any omissions.

6. *Don't* exaggerate. Any attempt to puff up your qualifications or to elaborate the extent of the examination you have made is apt to be exposed, to your embarrassment.

7. *Do* inform the attorney for the party who called you as a witness of all unfavorable information developed by your examination of the party, as well as the favorable information.

8. *Don't* try to bluff. If you don't know the answer to a question, don't guess. If you guess wrong, you may be falling into a trap.

9. *Do* be frank about financial arrangements with the party who called you as a witness, with respect to your compensation for both treatment given and services in connection with the litigation.

10. *Don't* regard it as an admission of ignorance to indicate that your opinion is not absolutely conclusive or that you don't know the answer to a particular question. Honesty may frequently require testimony of this nature.

11. *Do* answer all questions honestly and frankly. Any display of embarrassment or reluctance to answer will tend to discredit your testimony.

12. *Don't* use technical terminology which will not be understood by the jury, the attorneys, or the judge. If technical terms are unavoidable, explain them the best you can in the language of the layman.

13. *Do* be willing to disagree with so-called authorities if you are convinced that they are wrong. If you have sound reasons for disagreement, the contrary opinion of authorities will not necessarily discredit you.

14. *Don't* be smug. A jury is quite likely to react adversely to an attitude of this nature. A modest attitude on the part of a witness is apt to elicit a more favorable response. Leave it to the attorney to bring out your special qualifications.

15. *Do* be courteous no matter what the provocation. If a cross-examining attorney is discourteous to you, this is apt to win sympathy for you from the jury, provided that you don't descend to the same level.

16. *Don't* lose your temper. If a cross-examining attorney can provoke you to a display of anger or sarcasm, he has already substantially succeeded in discrediting your testimony.

17. *Do* pause briefly before answering a question asked on cross-examination, to give the other attorney an opportunity to object to the question if he so desires. Taking a moment for deliberation before answering a question does not indicate uncertainty or embarrassment.

18. *Don't* allow yourself to be forced into a flat "Yes" or "No" answer if a qualified answer is required. You have a right to explain or qualify your answer if that is necessary for a truthful answer.

ASTHMA: IMMUNOLOGICAL AND NON-IMMUNOLOGICAL

One of a series of case reports illustrating the differential diagnosis in patients with symptoms of asthma.

IRVIN CAPLIN, M.D.
JOHN T. HAYNES, M.D.
Indianapolis

A 62-year-old man was seen because of dyspnea of five years duration. He had smoked two packages of cigarettes daily from the age of eighteen; he quit five years previously with the onset of his dyspnea. There was marked improvement, although he still had a chronic cough, wheezing and dyspnea with slight exertion. He gave a history of repeated attacks of hemoptysis during his early adult life.

He developed a bleeding duodenal ulcer at age 59 which had been fairly well controlled with diet and antacids. He was seen because of a marked increase in his dyspnea and the development of a profound weakness.

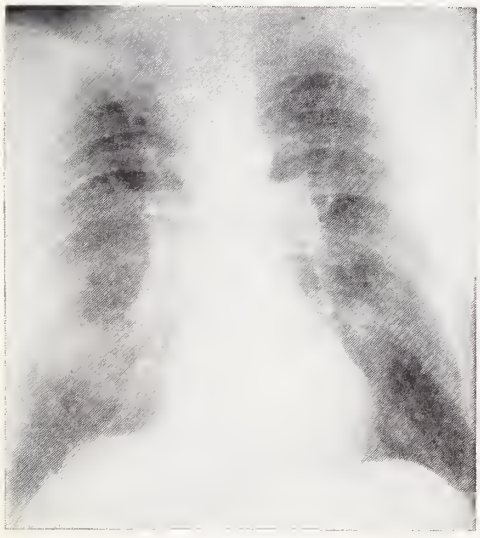


FIGURE 1
MARKED pulmonary emphysema. Flat diaphragm, transverse ribs and pulmonary fibrosis are demonstrated.

Physical examination revealed pallor and labored breathing. The conjunctivae and fingernails were pale. There was a marked increase in the A-P diameter of the chest. Heart sounds were distant. Blood pressure was 140/80. The lungs revealed rhonchi on forced expiration. There was no evidence of left- or right-sided heart failure. Rectal examination revealed the presence of tarry stools.

Pertinent laboratory data showed a hemoglobin of nine grams and a hematocrit reading of 30%. A timed vital capacity was done with evidence of bronchial obstruction. First second capacity was 0.9 liters with a total capacity of 2.4 liters. (Normal individuals without bronchial obstruction can expire approximately 80% of their total vital capacity in one second). A cardiogram revealed a sinus tachycardia, right axis deviation and slight S-T changes. A chest x-ray (Figure 1) revealed the presence of emphysema with nodular fibrotic areas toward the apices. A tuberculin test with 1-10,000 old tuberculin was positive. Sputum examinations were negative for acid fast bacilli.

A diagnosis of bleeding duodenal ulcer and pulmonary emphysema was made. He was treated with diet, antacids, Trinsicon, iodides and bronchodilators. Three months later, his weakness had disappeared and the dyspnea was less severe. His hemoglobin had risen to 16.4 grams and his hematocrit reading to 46%.

This patient demonstrated the secondary polycythemia seen frequently with the hypoxemia of pulmonary emphysema. It also demonstrates the syndrome described by Weber[1] of the frequency of upper gastrointestinal disease in the presence of chronic pulmonary disease. This man may have had a pulmonary tuberculosis earlier in life. Again, we have a non-allergic wheezer who presented for the allergic care of his "asthma."

REFERENCES

1. Weber, John, Gregg, L. A.: Co-incidence of Benign Gastric Ulcer and Chronic Pulmonary Disease, *Ann. Int. Med.* 42:1026-1030, May, 1955.

1815 N. Capitol Ave.
Indianapolis

Frankly, most antihypertensives are pretty good if you give an adequate dose. I'm looking for one with a simple regimen so that mix-ups in doses and therefore the chance of side effects are minimized.

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1 tablet daily brings pressure down

Advantage: Both components of Regroton are long-acting.
Average dosage: One tablet daily with breakfast.
Contraindications: History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases.
Warning: Discontinue 2 weeks before general anesthesia, 1 week before electroshock therapy, and if depression or peptic ulcer occurs. With administration of enteric-coated potassium supplements, the possibility of small bowel lesions should be kept in mind.
Precautions: Reduce dosage of concomitant antihypertensive agents by one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take particular care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use with caution in patients with ulcerative colitis, gallstones, or bronchial asthma.
Side effects: Nausea, vomiting, diarrhea, muscle cramps, headaches and dizziness. Potential side effects include angina pectoris, anxiety, depression, drowsiness, hyperglycemia, hyperuricemia, lassitude, leukopenia, nasal stuffiness, nightmare, purpura, urticaria, and weakness.
For full details, see the complete prescribing information.
Availability: Bottles of 100 and 1000 tablets.

Geigy

The Journal
of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

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Brand vs. Generic Names

IDENTIFICATION of the source of a product has always been an advantage for the user and, with a product of good quality, a matter of pride for the maker.

Nothing was ever devised by mankind, to provide the inspiration for and the guarantee of excellence, to rival the custom of a superior workman to sign his work or otherwise identify himself with his creation.

Artisans like Stradivarius have made their names so famous as to make unnecessary the mention of their product. Someone in Washington should tell Heifitz how much money he could save with a "generic" violin.

It is self-evident that rules for quality apply to drugs as well as to all other products; and in the case of drugs where casual observation, even by an expert, is of little aid in determining quality, the name, honor and reputation of the maker is of supreme importance.

If large sums of money were to be saved by prescribing generic drugs of unidentified origin, the present suggestions for the universal use of generic drugs might have some rational basis. However, a review of several thousand prescriptions written for a welfare service shows that, if all the drugs were dispensed as generic items, only five percent of the cost would have been saved from the cost of brand name products.

The level of manufacturers' prices for all prescription drugs has been falling for the past several years while the cost of living index has been rising. During this same length of time, the price of patented drugs has fallen faster than the price of non-patented drugs.

Brand name pharmaceuticals are not expensive; their cost covers the one ingredient without price — the guarantee of highest quality enjoined by the pride of workmanship.

In the life-saving business, a cheap drug might be the most expensive thing in the world.

Guest Editorials

Phenylketonuria (PKU) Testing*

THE Indiana State Board of Health at a regularly scheduled meeting on February 4, 1966, adopted a policy to be used in carrying out the intent of the law enacted by the Indiana General Assembly at its 1965 regular session. This policy is for the purpose of accomplishing comprehensive screening of all newborn infants in Indiana for the detection and control of the disorder — phenylketonuria — and is based upon the advice of a committee of medical authorities to the Indiana State Board of Health. The policy consists of the following:

It is recommended —

1. That in each hospital with services for the newborn the medical staff responsible for those services, in cooperation with hospital administration, set up a screening program for the detection of PKU in all newborn infants.
2. That tests used in a screening program be of a type known to be reliable 24 hours after the first milk feeding in infants of normal weight. The test shall be done prior to an infant's discharge from the hospital.**
3. That infants of below normal birth weights be screened when normal feeding patterns have been established and prior to discharge from the hospital.
4. That infants showing evidence of elevated blood phenylalanine levels on screening be promptly reported to the attending physician for appropriate follow-up diagnostic pro-

*Policy of the Indiana State Board of Health.

**Procedures using blood are the only methods now known to be satisfactory for detecting PKU in the first few days of life.

cedures to establish or rule out PKU.

5. That infants determined to have evidence of elevated phenylalanine levels on screening examinations be reported to the local board of health and in turn to the Indiana State Board of Health.
6. That all infants be retested for PKU at four-six weeks as a part of regular well child care.

The PKU testing law requires that the Indiana State Board of Health at least quarterly ascertain the extent of testing. As a part of a hospital's PKU screening program, it is recommended that records be kept showing the number of infants tested along with the number of negative tests and positive tests.

The Indiana State Board of Health will provide, upon request, consultation on the setting up of PKU screening programs.

Management of Hemophiliacs

AT the recent meeting held by The National Hemophilia Foundation in Philadelphia, considerable interest at evident misinformation with respect to the development of the refractory state in hemophilia was displayed. It was furthermore obvious that in many sections of the country, there is considerable hesitancy on the part of the individual physician to utilize plasma in a bleeding episode because of a fear of inducing refractoriness. Because this fear seems to be over-emphasized to the detriment of treatment in hemophilia, the following statement as evolved at the panel discussion of the Medical Advisory Council is provided. Participants in the panel discussion were Dr. Kenneth M. Brinkhous, Dr. Louis K. Diamond, Dr. Henry H. Jordan, Dr. Jessica H. Lewis, Dr. Armand Quick, Dr. Irving Shulman, Dr. Louis Wasserman and Dr. William P. Webster.

This panel estimated that the frequency of refractory state in hemophilia ranged between one and five percent. Members of the panel felt that refractoriness develops both in relation to administration of plasma or fractions with about equal frequency. Furthermore, it was felt that some individuals seemed almost immune to the development of the refractory state whereas others were seemingly prone to developing such a state. The members of the panel were unanimous in declaring that a bleeding episode severe enough to require plasma therapy or its equivalent should be treated promptly with plasma without regard to the possible fear of inducing a refractory state.

Because of the infrequency of the development of the refractory state and the unpredictability of its arising, and the very real potential for damage by a bleeding episode, the dictum was stated, "One treats the present and doesn't worry about the future." It is therefore worthy of emphasis once more to state that while the refractory state in hemophilia is troublesome and of real concern once it develops, there is no valid reason to hesitate in treating a bleeding episode that requires therapy on the basis of fear of developing plasma refractoriness. Of equal importance is the necessity of giving enough plasma to adequately control a hemorrhagic episode.

There is a tendency on the part of the uninitiated physician to give one unit of plasma and with the bleeding stopped, give no more until bleeding resumes a day or two later.

It should be emphasized that fresh or fresh frozen plasma must be administered daily or twice daily until the bleeding site has solidly healed.

While individual cases will necessitate individualized treatment, the following general guide to various bleeding problems is suggested.

1. Dental extractions — One or two units of plasma daily for five days.
2. Soft tissue hemorrhage — One or two units of plasma daily for five days.
3. Visceral and joint bleeding — Two units daily for 10 days.
4. Major surgical or major traumatic episodes — Two or more units daily for 14 to 21 days.

For external blood loss whole blood may be required.

REMEMBER — THE PATIENT WILL SHOW NO EVIDENCE OF FURTHER BLOOD LOSS AND YET REQUIRE DAILY AHG OR PTC SUPPLEMENTATION TILL THE WOUND HAS COMPLETELY HEALED. — **Drs. Robert J. Rohn and Jack Spevak, members of the Medical Advisory Council to the Indiana State Chapter of the National Hemophilia Foundation.**

Personalized Health Hazard Appraisal

SINCE March, 1964, a committee of general practitioners at Methodist Hospital Graduate Medical Center has been working in a project called Health Hazard Programming. The work of this committee has been to develop early methods for the study of preventive medicine as it applies to the treatment of the individual patient by a family physician.

At each weekly meeting, a patient is presented. Discussion of the risks of death and possible risk reduction follows. After the individual risks are adapted from the average death tables, attempts are made to plan procedures which deal with both existing pathology and potential problems. In diagnostic medicine, methods of study and care are based upon indications. The indications for preventive medicine are the risk of disease and the possibility of reducing that risk.

Risk factors are available for some areas in more complete form than in others. Where these factors are available from epidemiologists in cancer, heart disease and others, they are used. If from experience the practicing physicians have a hint that certain factors are related to risk, these are discussed. Some tables of risk factors are available.

Health hazard programming or appraisal is accomplished by arriving at modifications of average hazards as they relate to a particular case. The modifications are obtained through

free discussion. To systematize the approach, the hazard of each disease group is considered three times, using a different stage of information on each review. The first step in individualization is based on the history and physical alone. Each disease group is similarly considered after routine laboratory tests which are urinalysis, complete blood count, serology for syphilis, chest x-ray, sedimentation rate and Papanicolaou smear of the cervix in women. Changes in health hazard estimates are based next on special studies, if any, obtained. This step includes consultation reports. In concluding discussion of the case, the conferees arrive at recommendations for management of the patient as indicated by his health hazards — the best estimate of relative risks listed in the third step. In the fourth stage, the risks are stated as though complete participation of the patient is obtained. Any further appraisal will depend upon demonstrated participation.

The discipline of health hazard appraisal provides the busy practitioner with a method for selecting procedures and examinations most beneficial to his patient. The plan of prospective medicine illustrated by numerical values for risks can be used to motivate patient participation in the premorbid situation. Initial appraisal may be completed in about 15 minutes.

The patients in the study are all private patients who will be followed for ten years. Evaluation of participation as well as change in death rate is anticipated.—**Marilyn M. Sanders, M.D., Methodist Hospital Graduate Medical Center, Indianapolis.**

Editorial Notes...

The Dean of Butler University College of Pharmacy, Karl L. Kaufman, is sponsoring a movement to encourage the U. S. Post Office Department to issue a commemorative stamp in honor of the 150th anniversary of the birth of William Proctor, Jr., "The Father of American Pharmacy." The medical profession can join wholeheartedly in this movement to call attention to the innumerable public health benefactions contributed by the pharmaceutical profession, one of medicine's staunchest allies in the health service fraternity.

Usually moonshining and "lead poisoning" are associated due to the lead bullets of revenuers. There is another type. The University of Alabama has found that almost all their patients with plumbism and gout were heavy drinkers of moonshine. Samples of moonshine liquor have assayed heavy in lead, said to have gained access to the beverage because sour mash "leaches" the lead from the solder used to construct the still. The lead content varies from 1,000 meg. to 200,000 meg. per liter. Saturnine (pertaining to lead) gout was recognized early in the 18th century but almost forgotten until recently. The researchers are now attempting to determine why lead poisoning causes gout, and in the meantime offer advice that it is safer to pay the tax on liquor and avoid the lead.

Measurement of minute quantities of radiation from a patient's body can be done accurately and in extremely small amounts only in a room which is screened from external radiation. The best screening material is old steel plate, old enough to have been made before the atomic era started and hence without any "built-in" radiation of its own. The Battleship U.S.S. Indiana is a popular source of old plate; sixty-five tons of its eight-inch armor plate are being installed in the VA Hospital at Hines, Illinois. Sixty-five tons sounds like a lot of steel, but will enclose a space only eight feet high, eight feet wide and ten feet in depth.

The Veterans Administration is issuing identification bracelets or necklaces to veterans with serious medical problems which may require urgent treatment if the patient is unconscious from accident or sudden illness. Information about pacemakers, unusual reactions to drugs, diabetes and epilepsy are typical examples. The devices will be furnished without regard to service-connected disability.

The American people are great movers. In a recent twelve-month period, 38,000,000 or about one-fifth of the population changed residences. Two-thirds of these moves were within the same county. The remaining one-third of the movers were divided about equally between those who moved within the same state and those who moved to another state. Most of the movers were in the 20 to 30 age bracket. Above 30, the older they are, the less they move. California now attracts most of the interstate migrations, and also has more intrastate moves than any other state.

A mobile hyperbaric recompression chamber has been acquired for rescue work by the city of Chicago. The treatment chamber and two high-pressure air tanks are transported on a trailer and will be used for treatment of victims of smoke inhalation, divers with the "bends," and any other patients with conditions amenable to hyperbaric oxygen who cannot be transported to a suitable hospital in less time than the mobile chamber can reach them.

Purdue University has discovered that automobile engines with big cylinders, fewer of them and lower compression are all factors which tend to lessen the concentration of unburned hydrocarbons in the exhaust and would therefore help solve the problem of atmospheric pollution. Present engines would not pollute the air so much if they ran a lot hotter, but the cost of making cylinder walls which will withstand temperatures high enough to solve the incomplete combustion problem would be too expensive. ◄

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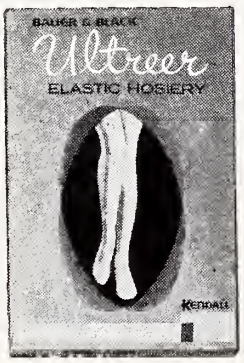
charm her with Ultreer™

You see, a woman simply has no defense against Ultreer Elastic Stockings. They look like lovely support stockings. They feel like lovely support stockings. They're that sheer, and shapely and comfortable.

But that's where the similarities end. New Ultreer fits firmly and evenly over the entire leg. Gives true therapeutic compression necessary to relieve varicose veins and other leg disorders. Each pair provides the therapy you prescribe. And at such a low price, a woman can afford two pairs of Ultreer as easily as she can afford one pair of ordinary elastic hosiery.

Ultreer. What a stocking.



KENDALL

BAUER & BLACK SUPPORTS DIVISION

President's Page

After reviewing the myriad rules and regulations that have emanated from federal and state agencies and after studying directives issued by "carriers," it is apparent that there is a concerted effort being made to confuse the physician, the patient and perhaps even the governmental agencies and carriers.

There seems to be a definite inclination for governmental agencies to re-write the laws by their regulations, and then delay the publication of the regulations until objection is of no avail because of the lack of time to protest.

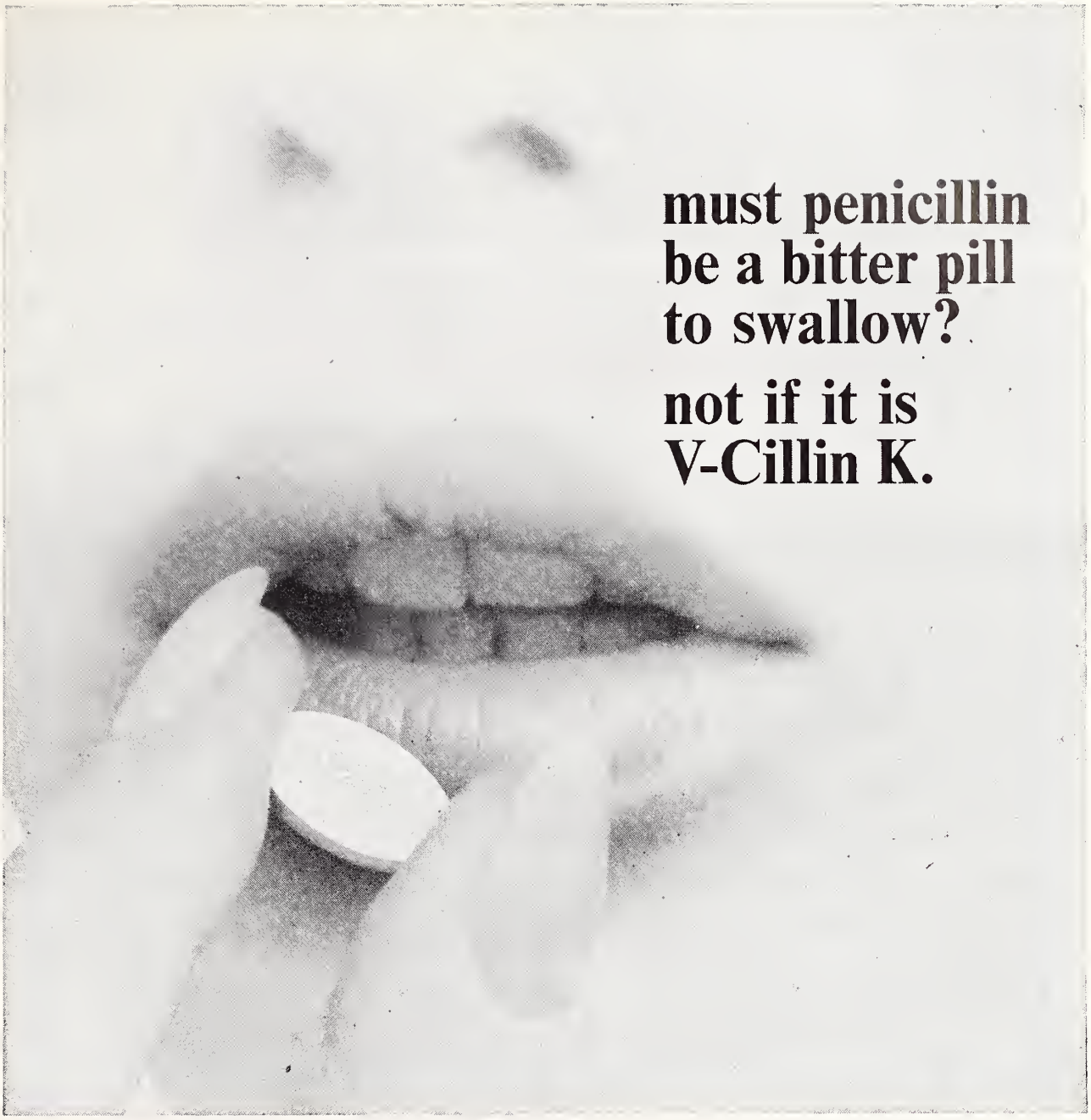
As a preview of the future, I should like to quote from a news item "lost" in the inner pages of *The Indianapolis Star* on July 21, 1966. In speaking to a group attending a program on hospital finances at the Indiana University School of Business, "A Federal representative said that socialized medicine did not arrive full-blown in the United States as it did in Great Britain." Charles A. Cubbler, consultant for medical care administration to the Department of Health, Education and Welfare is quoted as saying, "In the U.S. we have chosen to make it an evolutionary process and bring it about piece by piece over the next ten years."

This should be fair warning of what we can expect. This should challenge us to make every effort we can; by working, voting and supporting with time and money any program or person that can help retire such a philosophy.

It should be apparent to all of us that fragmentation of the medical profession is being systematically encouraged by government, labor and even carriers. The Federal Government is so confident of reaching its objective, they no longer hesitate to spell out their "Ten Year Plan" in the public press.

What are YOU doing to prevent this "evolutionary process?"

H. D. Neumann M.D.



V-Cillin K now has a unique glossy coating that banishes bitter penicillin taste and makes it easier to swallow. Within six seconds (just long enough for the tablet to get past the taste buds), the coating dissolves and the penicillin is ready for immediate absorption into the bloodstream. The patient still gets all the special benefits of V-Cillin K, including consistent dependability . . . even in the presence of food.

Indications: V-Cillin K is an antibiotic useful in the treatment of infections caused by streptococci, pneumococci, and sensitive strains of staphylococci.

Contraindications and Precautions: Although sensitivity reactions are much less common after oral than after parenteral administration, V-Cillin K should not be administered to patients with a history of allergy to penicillin. As with any antibiotic, observation for overgrowth of nonsusceptible organisms during treatment is important.

Usual Dosage Range: 125 mg. (200,000 units) three times a day to 250 mg. every four hours.

Supplied: Tablets V-Cillin K, 125 or 250 mg.; also, V-Cillin K, Pediatric, 125 mg. per 5-cc. teaspoonful, in 40, 80, and 150-cc.-size packages.

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Six-Second Barrier to Bitterness

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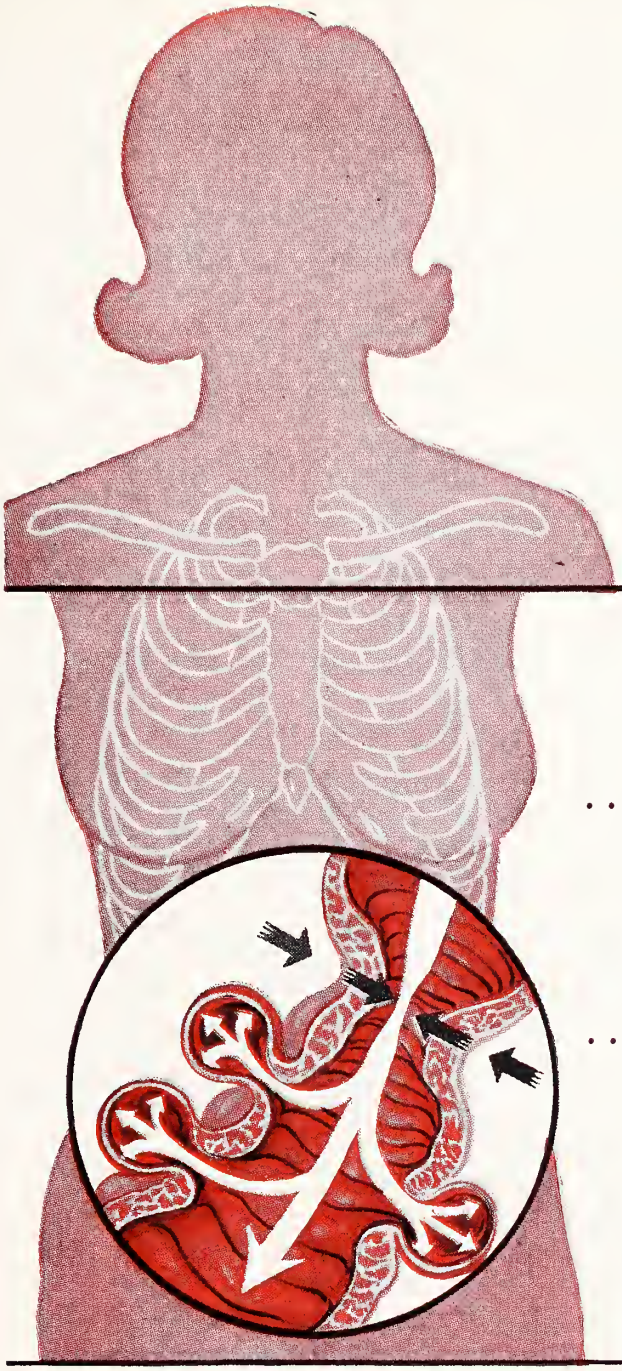

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. . . to counteract the constipation which is etiologically important and

. . . to protect the mucosal surface against physical irritants.

Average Adult Dosage:

One rounded teaspoonful of Metamucil (or one packet of Instant Mix Metamucil) in a glass of cool liquid one to three times daily.

SEARLE

Research in the Service of Medicine

The Woman's Auxiliary

REPORTS TO ISMA

A thrilling and rewarding highlight of the 43rd annual Convention of the Woman's Auxiliary to the AMA was the AMA-ERF Awards Luncheon, held at the Drake Hotel, Chicago, on June 28. Indiana, with its total contribution of $17,650.80, received the bronze plaque for the state, in its membership category, contributing the largest amount. Vanderburgh-Southwestern was awarded the certificate for the county, in its membership range, making the largest contribution.

The check presented this year to the AMA, representing the total gift from the doctors' wives of the 50 states, was for $345,573.81, the largest amount ever given in one year and an eight percent increase over 1955. The funds are accumulated by the members of the constituent auxiliaries through the sale of Christmas cards, stationery and playing cards; through "memorial" and "appreciation" cards, rummage sales, benefit card parties and dances; in fact, by every conceivable legitimate method of fund raising.

Many deserving medical students, interns and residents have and are using scholarships provided from the AMA-ERF (American Medical Association Education and Research Foundation). Some gifts are earmarked for certain medical schools while other monies are placed in an unrestricted fund for distribution on a pro-rated basis. The new Institute for Biomedical Research located at the AMA Headquarters, which was dedicated in October, 1965, is now to receive a share of these funds. Over the 15 years, since the original AMEF (American Medical Education Foundation) was set up, the dedicated members of the woman's auxiliary have presented to the AMA more than two million dollars.

May I call your attention to your state convention which convenes at the French Lick Sheraton Hotel on October 10 for a three day session? This year the wives attending will have the privilege of participating in the annual Workshop of the auxiliary. Instead of having the three area Workshops in September, the Executive Committee has decided to devote the last day, October 12, to the explanation and challenge of the auxiliary program. Each state chairman will present the purpose and program of her department. Most of these will have just returned from Chicago where the North Central Regional Workshop will be held October 4-5. Their enthusiasm will be contagious and their "cup of information" filled to overflowing.

I solicit your help in encouraging your wives to attend the convention with you and take advantage of this opportunity to cooperate in a most worthwhile and rewarding program.

Mazo D. Scales

INDIANA STATE BOARD OF HEALTH

MONTHLY REPORT—June, 1966

Disease	June 1966	May 1966	Apr. 1966	June 1965	June 1964
Animal Bites	1476	1135	844	1575	904
Chickenpox	196	344	481	304	723
Conjunctivitis	131	140	134	156	207
Diphtheria	0	1	0	0	0
Dysentery, Unspecified	37	33	35	53	71
Gonorrhea	497	303	368	443	312
Impetigo	86	65	68	143	146
Infectious Hepatitis	28	30	34	52	71
Infectious Mononucleosis	48	52	98	40	97
Influenza	360	869	1694	199	506
Measles (Rubeola-Rubella)	1241	1681	1456	629	6868
Meningitis, Meningococcic	8	16	12	7	9
Meningitis, Other	6	5	2	6	9
Mumps	309	250	402	324	1422
Pertussis	5	18	9	13	53
Pneumonia	419	607	548	182	344
Poliomyelitis	0	0	0	0	0
Streptococcal Infection	513	606	1178	437	903
Syphilis					
Primary and Secondary	9	14	4	7	6
All Other Syphilis	119	95	94	92	105
Tinea Capitis	4	4	13	14	27
Tuberculosis (Active)	102	76	59	125	169

SCIENTIFIC EXHIBIT APPLICATION FORM

Committee on Scientific Exhibits
Indiana State Medical Association
3935 N. Meridian Street
Indianapolis, Indiana 46208

Please send me an application form for a Scientific Exhibit at the ISMA Annual Convention, October 10-13, 1966, French Lick, Indiana.

I propose to exhibit_____

_____

_____

Name_____

Address_____

City_____

State_____

Art, Hobby Show Planned For ISMA French Lick Meeting

Space will be provided at the 1966 annual meeting of the Indiana State Medical Association, Oct. 10-13 at French Lick for a Physicians Art and Hobby Show.

Members of ISMA interested in exhibiting pieces and requiring any information regarding this can contact any one of the following:

Dr. Charles P. Schneider
2211 W. Franklin St.
Evansville

Dr. Ray H. Burnikel
517 Sycamore St.
Evansville

Dr. Truman E. Caylor
303 S. Main St.
Bluffton

Dr. Frank H. Coble
51 S. Eighth Street
Richmond

Dr. Lall G. Montgomery
Ball Memorial Hospital
Muncie

ISMA Headquarters
3935 N. Meridian
Indianapolis

It will be the responsibility of each physician to see that his work gets to the exhibition at the French Lick-Sheraton Hotel. Final arrangements will be taken care of by Drs. Schneider and Burnikel, co-chairmen.

The ISMA will provide suitable display facilities, but each physician is responsible for transportation costs and any other such expense involved in entering his exhibit.

We solicit your exhibit to make this the largest and best ever this year.

Application for Space in Art and Hobby Show Exhibit

Mail to:

Dr. Charles P. Schneider
2211 W. Franklin St.
Evansville

Name_____

Address_____

City_____

Type and number of pieces to be displayed: Photography_____

Sculpture_____

Crafts_____

Painting_____

Other_____

Estimated amount of space required—lineal or square feet_____

Other information_____

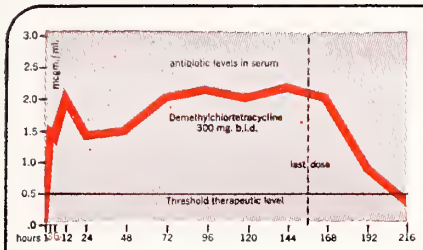
greater potency

lower mg intake per day

600 mg versus 1,000 mg

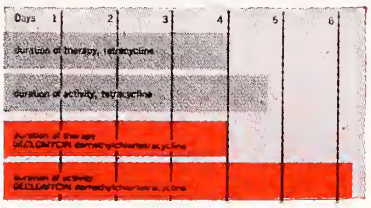
in G.U. infections

broad-spectrum performance



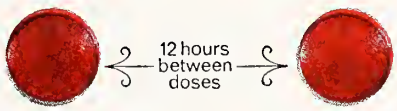
high activity

From Sweeney, W. M., Dornbush, A. C., and Hardy, S. M., Amer. J. Med. Sci. 243:296 (Mar.) 1962



1-2 "extra" days' activity

after the last dose to protect against relapse



one 300 mg Tablet mid-morning

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DEMETHYLCHLORTETRACYCLINE

Effective in a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill—when the offending organisms are tetracycline-sensitive.

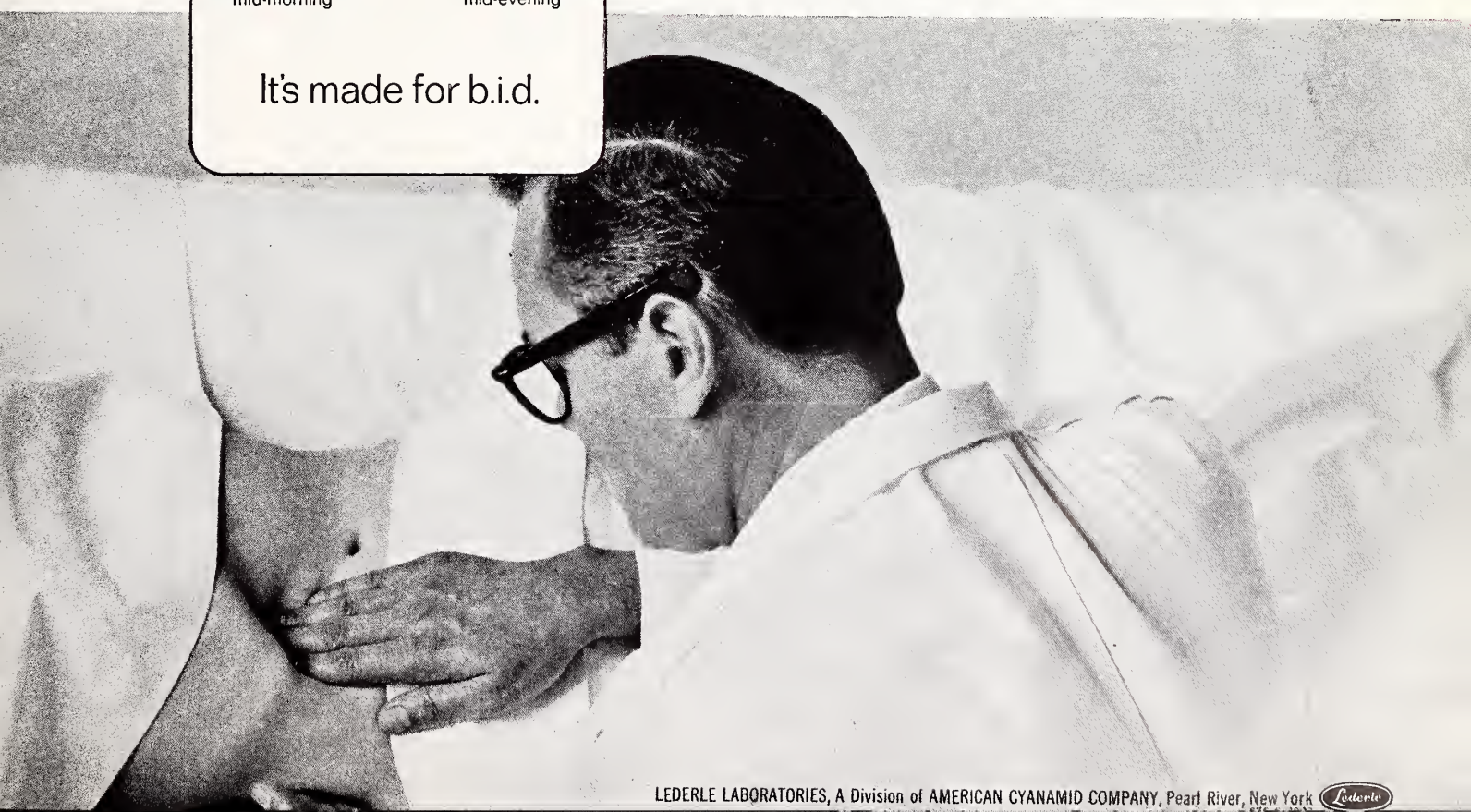
Contraindication—History of hypersensitivity to demethylchlortetracycline.

Warning—In renal impairment, usual doses may lead to excessive systemic accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort.

Precautions and Side Effects—Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. Use of demethylchlortetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect occurs mostly during long-term use but has also been observed in short treatment courses. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment. Side reactions include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and dermatitis. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Anaphylactoid reactions have been reported.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products.

Capsules: 150 mg; *Tablets:* film coated, 300 mg, 150 mg, and 75 mg of demethylchlortetracycline HCl.



LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Hospital Practice

A Pilot Project in Health Hazard Programming*

A systemized method of management and prevention of disease is being studied by the General Practice Education Committee of the Methodist Hospital in Indianapolis. Members of the hospital's General Practice Department, who are interested in teaching, serve as preceptors for medical students, and meet at intervals in conference to discuss the prognosis of their own private patients whose medical records have been prepared by the assigned student.

Public Health Service standard tables of probability of death within ten years for each of the leading causes of death are available for various races, each sex and for the various age groups.

At the first conference a modifying numerical factor is assigned for each specific hazard as it relates to the case at hand as determined by consideration of history and physical examination alone. These numbers are posted in column No. 1.

Another numerical factor is posted in column No. 2, to indicate a re-evaluation of each hazard as a result of knowledge of the urinalysis, complete blood count, serology, chest x-ray, sedimentation rate, and the Papanicolaou smear of the cervix in women.

Column No. 3 lists the factor as determined by all special studies, including other x-rays, other laboratory studies and consultation reports.

After the conferees have made recommendations for management of the patient in relation to his health hazards, numerical factors are entered in column No. 4 in accordance with the expected success of the preventive management.

* See editorial, p. 915.

The following is the protocol of a patient who was studied and prognosticated by this system:

Patient: A 39-year-old white female.

Chief Complaint: Entered for routine physical examination.

Past History: T & A as a child and in 1961. Pneumonia in 1961. Two admissions to a Cincinnati hospital for acute depression in 1950 and 1952. She received electroshock therapy. Gravida IV, para I, abortus III.

Review of Systems: She has worn glasses for many years for myopia. She has some postnasal drip, without cough. Last menstrual period one week ago; periods are regular. Ten years ago she weighed 150 pounds, but lost to present weight of 125 pounds when her grandmother died.

Family History: Parents are living, 70 and 72, have heart disease. She has one sister, living and well. Only child is age 10 years. Divorced from husband. Several relatives on both sides have diabetes. A grandmother had cancer.

Socio-economic: She is a housewife, living alone with her daughter since divorce in 1963. She was married at age 18. Husband circumcised. She has smoked 40 cigarettes daily for 15 years. She drinks 20 cups of coffee a day. Dairy intake is low, except for two-four eggs each day. She did not nurse her baby. Drives 2,000 miles per year without seat belts.

Physical Examination: T 98°, P 80 (regular), R 14, ht. 67″, wt. 125 lb., BP 115/80. Some nasal congestion. Eyes — myopia on fundiscopic exam, otherwise normal. A few scattered rhonchi are heard in the chest. Both breasts have multiple shotty nodules, with no dominate nodules. Heart and abdomen are normal. She has a few small venous varicosities on her lower extremities. Pelvic — endocervical polyps.

Stage I

Malignant Neoplasms of Breast

Dr. Martin: "She has nodules in her breast."

Dr. Gray: "I'm always concerned about nodules in the breast because the chance of finding any new masses is doubly difficult."

Dr. Mouser: "I think we would have to up it on suspicion."

(Hazard increased to five times.)

Arteriosclerotic Heart Disease and Chronic Endocarditis

Dr. Hall: "She does have both a father and mother who are in their 70's and both have heart disease. Her blood pressure is normal."

Dr. Mouser: "I think we would have to leave that the same."

(Hazard unchanged.)

Vascular Lesions/CNS

Dr. Kammen: "Due to her lack of any hypertension and her age, I would decrease it to 0.75 times."

(Hazard decreased to 0.75 times.)

Malignant Neoplasms of Uterus

Dr. Gray: "Wouldn't the endocervical polyps increase the hazard for malignancy of the uterus?"

(Hazard decreased to 0.5 times.)

Chronic Rheumatic Heart Disease

Dr. Hall: "She has no findings on physical examination or history to support this. I'd drop it to half."

(Hazard decreased to 0.5 times.)

Cirrhosis of Liver

Dr. Hall: "According to the history she has one drink every six months. She has no history of hepatitis."
(Hazard unchanged.)

Malignant Neoplasms of Intestines and Rectum

Dr. Hall: "She has no history or complaints related to this."
(Hazard unchanged.)

Motor Vehicle Accidents

Dr. Hall: "She doesn't drive very much."

Dr. Mouser: "She doesn't use seat belts either. Most of her driving is probably around town where she needs seat belts."

Dr. Martin: "She may not be a very good driver. She probably is preoccupied and probably is smoking while she drives."
(Hazard increased three times.)

Suicide

Dr. Mouser: "She was hospitalized twice for acute depression."

Dr. Martin: "She is divorced and is emotionally instable."

Dr. Permer: "She is 39 and approaching the menopause."

Dr. Gray: "Her daughter is 10 now and in 10 years she will probably be married. This patient will then have nothing to focus her attention on, which no doubt is now focused on her daughter."
(Hazard increased to 100 times.)

Malignant Neoplasms of Lungs

Dr. Kammen: "I think with her smoking history it should increase ten times."
(Hazard increased 10 times.)

Pneumonia

Dr. Mouser: "She had pneumonia in 1961."

Dr. Hall: "She has a few scattered rhonchi in her chest now."

Dr. Mouser: "When she gets that Ca of the lung she is likely to get pneumonia as the terminal stage advances."
(Hazard increased to two times.)

Hypertensive Heart Disease

Dr. Mouser: "If she would stop smoking and stop drinking 20 cups of coffee each day, she would probably be hypotensive."
(Hazard decreased to 0.75 times.)

Lymphosarcoma

(Hazard unchanged.)

Diabetes Mellitus

Dr. Mouser: "In column 1 I'd like to introduce diabetes as less than 42."

Dr. Permer: "She has a good risk. There is history in her family of diabetes on both sides."

Dr. Mouser: "I think we should set it at about 35 and increase it about five times."
(Hazard set at 35 and increased five times.)

Stage II

Routine Laboratory

Urinalysis: appearance — straw, pH — acid, specific gravity 1.006, albumin — trace, sugar and acetone — negative, microscopic — many RBC's (bleeding vaginally), no WBC's or casts.

Blood: serology — VDRL — negative, hematocrit 40, hemoglobin 14.1, white cell count 10,600, differential — polys 59 (98% segs) small lymph 35, large lymph 2, eos. 2, baso. 1, mono. 1.

Chest x-ray: lungs, pleural spaces and mediastinum — negative.

Pap smear: November 1964 — negative.
(Hazards unchanged.)

Stage III

Programmed Studies

3-2-65 — Coagulation time 4½ minutes.

3-3-65 — 2-hour postprandial blood sugar 92mg%.

3-4-65 — Bilateral mammograms — severe fibrocystic disease. D & C, cone and endocervical polypectomy-secretory endometrium, chronic cervicitis, benign polyps.

Malignant Neoplasms of Breast

Dr. Martin: "Because of mammograms I think we can decrease the risk down to three times."
(Hazard decreased to three times.)

Malignant Neoplasms of Uterus

(Hazard decreased to normal because of the D&C and its findings.)

Stage IV

Preventive Medicine

Dr. Mouser: "I feel she should have mammograms every six months. If she would, then I'd decrease her risk for Ca of the breast.

TEN YEAR HEALTH HAZARD
White Female — 40

Order	Disease	Hazard	1	2	3	4
1.	Mal neop of breast	351	5	–	3	2
2.	Arter ht dis/chr endo	297	1	–	–	1
3.	Vascular lesions/CNS	200	.75	–	–	.75
4.	Mal neop of uterus	181	2	–	1	.01
5.	Chr rheum ht dis	133	.5	–	–	.5
6.	Cirrhosis of liver	133	1	–	–	1
7.	Mal neop of int & rec	109	1	–	–	1
8.	Motor vehicle accid	103	3	–	–	1.5
9.	Suicide	91	100	–	–	75
10.	Mal neop of lungs	60	10	–	–	2
11.	Pneumonia	60	2	–	–	2
12.	Hypertensive ht dis	49	.75	–	–	.75
13.	Lymphosarcoma	42	1	–	–	1
	Other causes	1,211				
	Diabetes mellitus	35	5	–	–	.75
	Total Causes	3,020	14,431	14,431	13,548	10,184

Malignant Neoplasms of Breast
(Hazard decreased to two times with six month checkups and mammograms.)

Malignant Neoplasms of Lungs
Dr. Stephens: "If we could get her to stop smoking we could reduce her risk."
(Hazard reduced to two times with the elimination of smoking.)

Diabetes Mellitus
Dr. Mouser: "I believe we can decrease this with observation and testing."
(Hazard decreased to 0.75 times if she is watched carefully for signs of diabetes and has frequent glucose tolerance tests.)

Suicide
(Hazard decreased to 75 times.)

Malignant Neoplasms of Uterus
(Hazard reduced to 0.01 times with annual Pap smear.)

Motor Vehicle Accidents
(Hazard reduced to 1.5 with the use of seat belts.) ◄

DAY BY DAY WITH THE FDA

From the FDA Reports on Enforcement and Compliance.

"Regimen Tablets," usually promoted for weight reduction, have been found to be the subject of fraudulent promotion by a Federal Court. One of the ingredients is phenylpropanolamine, a drug which will stunt the appetite if taken in doses large enough to be toxic, but which have no appetite effect in the recommended dose as contained in "Regimen."

* * *

Periodic investigations of the safety of the artificial sweetening agents, saccharin and the cyclamates, have demonstrated no side effects except a mild laxative effect with the ingestion of more than five grams of cyclamate per day. FDA tests during the past year have included animal studies and observations of the use of artificial sweeteners in children. Widespread use of the agents in low calorie foodstuffs has increased consumption far above what would be required for use in diabetic diets.

* * *

The preservation of eyesight received a big assist when $3,200 worth of contact lens cleaning and soaking solution was found to be bacteriologically contaminated and was destroyed. In another instance, tubes of ophthalmic ointment were destroyed because the ointment was found to contain metal particles.

* * *

FDA is issuing a hearty welcome to the South American woolly opossum, which has recently been recognized as a useful experimental animal. A true marsupial and about the size of an ordinary rat, the newcomer is distinguished by being a low count chromosome creature. Humans have 46, rats have 42, North American 'possums have 22; the South American has only 14. This makes him a natural for investigation of the effect of chemicals on genes.

* * *

A man in Los Angeles who was convicted of selling amphetamine tablets on the street without prescription was sentenced to jail for three years and denied probation when it was found that he had continued making street sales almost up to the time of sentencing.

* * *

Disposable insulin syringes have been discovered on the market and removed from sale because they were graduated with a unit scale which would have resulted in administering twice the desired dose of insulin. ◄

(...and we never touched our vacation money)

"I DON'T KNOW WHAT WE WOULD'VE DONE WITHOUT BLUE CROSS BLUE SHIELD"

A serious family illness is never much fun. But when it's so costly it wipes out the money set aside for a much-needed vacation, then it's doubly sad.

Best way to protect against such things happening, is a Blue Cross-Blue Shield membership. More than a million and a half Hoosiers think so. And a good many of them even write "thank you" notes that nearly always say the same thing: "I don't know what we would have done without Blue Cross-Blue Shield."

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(One of a series of ads being run in key Hoosier newspapers)

Report on Actions of the House of Delegates

American Medical Association
115th Annual Convention
June 26-30, 1966
Chicago

AN INDIANA-SPONSORED resolution was adopted by the AMA House of Delegates at its annual convention June 26-30 in Chicago.

The resolution called upon specialty groups and specialty boards to impose the Principles of Medical Ethics upon their membership. The House adopted the resolution with the exception of changing the resolve to make it apply to all physicians instead of just specialty groups.

Dr. E. S. Jones of Hammond was elected vice-president of the AMA and Dr. Guy A. Owsley of Hartford City was elected to a five-year-term on the Council of Medical Service. James A. Waggener, Executive Secretary of ISMA, was re-elected for another term as secretary-treasurer of the Conference of Presidents and Other Officers, a position to which he has been elected for 13 consecutive years.

Indiana received two awards: first place in Class Two, 4,000-9,999, for the largest amount contributed by physicians to AMA-ERF and a first place award in Class Two for the highest per capita giving by physicians.

The Indiana State Medical Association was represented by all AMA delegates and alternate delegates as well as members of the Executive Committee.

Other items which came before the House of Delegates included Federal health legislation, physicians' billing procedures, medical ethics, racial discrimination, health manpower and an increase in AMA annual dues.

Dr. Milford O. Rouse of Dallas, Texas, Speaker of the House of Delegates for the past three years, was named AMA president-elect by acclamation. He will succeed Dr. Charles L. Hudson of Cleveland, Ohio, who took office at the Tuesday afternoon inaugural ceremony during the Chicago convention.

The 1966 AMA Distinguished Service Award was voted to Dr. Warren H. Cole of Chicago, head of the Department of Surgery at the University of Illinois College of Medicine, for his work in cancer research and his many contributions to medical literature.

The Layman's Citation for Distinguished Service was awarded to Danny Thomas, well known entertainer in radio, television, motion pictures and the stage, for his leadership in founding the St. Jude Children's Research Hospital at Memphis, Tennessee.

Final registration reached a total of 35,506, made up of 12,445 physicians and 23,061 guests.

Federal Health Legislation

The House of Delegates received and considered a large number of reports and resolutions dealing with Medicare, the expanded Kerr-Mills program under Title 19 of Public Law 89-97 and other federal laws or programs.

In accepting and commending a board of trustees report on Medicare, the House recommended that "the association give wide dissemination to the information contained therein, particularly its informed discussion of direct billing, the basic purposes of utilization review, the rejection of compensation for service on such committees except in exceptional circumstances, and the proper placement of any onus of responsibility for any failure in the Medicare program."

The board report ended with the following conclusion:

"During the past year many individuals have represented the American Medical Association and the physicians of the United States by meeting frequently with officials of the Department of Health, Education and Welfare. This degree of cooperation on our part should be viewed as a recognition by responsible citizens of an obligation to obey the law of the land, including this law with which we disagree. Our specific purposes have been to provide expert assistance to the government so that this law could be implemented in a manner most helpful to the beneficiaries while disturbing the practice of medicine to the minimum degree. Despite our best efforts it is apparent that serious problems are inevitable in connection with the implementation of this law and we trust that the physicians and the public will place the blame for such deficiencies squarely where they belong — on the Federal Government.

"We are proud of the role we have assumed and in many instances our efforts have been productive. Proposed forms were simplified; some unnecessary forms eliminated, and a number of our suggestions were incorporated in regulations and procedures. An informative 'Reference Guide' for physicians, recently distributed, was prepared with consultation of AMA staff. Numerous other items will continue to receive our most serious study and consideration, and the board urges and requests that every member exhibit his personal diligence by supplying his local medical society documented evidence of transgressions of the spirit or the letter of the law as it is implemented.

"The board of trustees intends to continue to supply advice, guidance, and dissent when necessary to the government or to other third parties on matters that pertain to the health of the public and the interests of the medical profession."

The House strongly supported the general concept of individual responsibility and endorsed a report from the Council on Medical Service which included the following statement:

"Since the Council believes that the current interest in the doctrine of individual responsibility stems in large part from concern over the matter of

assignments under PL 89-97, it hastens to add that, as a matter of American Medical Association policy, the Council on Medical Service recommends reaffirmation of the responsibility of individual physicians for determining how they will govern their professional practices under this law and that physicians should be made acutely aware of the manifest superiorities of direct billing as previously communicated to this House in the Council's Report E (A-66) on 'Recommendations on the Physician's Role in Medicare.' "

The latter report (Report E) was highly commended, and the House recommended its widest possible dissemination, including publication in its entirety in a prominent place in the earliest possible issue of *AMA News*.

CITATIONS for "performance in behalf of the AMA-ERF," denoting the highest per capita donation given during 1965 were presented at the AMA Annual Convention to four state medical associations. Accepting them from Dr. Raymond McKeown, (center) Coos Bay, Ore., Foundation president were (left to right) Drs. Edward W. Cannady, East St. Louis, Ill.; Guy A. Owsley, Hartford City, Ind.; Drew M. Petersen, Ogden, Utah and Harland B. Anderson, Casper, Wyo.

Physicians' Billing Procedures

In connection with the Medicare part of Public Law 89-97, the House also adopted three resolutions which recommended that physicians use the direct billing method rather than the assignment procedure. At the same time, the House pointed out that adoption of these resolutions should not be interpreted as contravening the statement approved at the Special Session in October, 1965, which said:

"The American Medical Association opposes any program of dictation, interference or coercion, whether direct or indirect, affecting the freedom of choice of the physician to determine for himself the extent and manner of participation or financial arrangement under which he shall provide medical care to patients under Public Law 89-97."

In considering a resolution on the right to bill patients under Title 19 of the law, the House passed an amendment pointing out that direct billing has been recommended as the billing method of choice under Title 18 by the Board of Trustees and the Council on Medical Service. It then said that since there is a wide latitude available to the states in establishing administrative procedures under Title 19, each state medical association should work early and diligently in its own state so that any plan or law adopted in its state for approval under Title 19 would include authorization for direct billing.

The House also instructed the AMA Advisory Committee to the Department of Health, Education and Welfare to do all in its power to implement the intent of the resolution at the national level. In addition, the House urged positive steps to obtain statutory authority for a continuing medical advisory committee under Title 19, and it called on the AMA and the state societies to maintain added vigilance to eliminate any patterns which might subvert the intent of Title 19.

Hospital-based Physicians

The House passed two resolutions involving billing and reimbursement principles affecting hospital-based specialists but also of significance to all physicians. The first said:

"The Principles of Medical Ethics declare that a physician shall not dispose of his services to a third party or 'lay' organization, and

"Title XVIII of Public Law 89-97 recognizes the principle of the separation of professional and hospital costs for services rendered by hospital-based physicians; and

"This principle has been advocated by the AMA, the American College of Radiology, the American College of Pathologists, and many regional organizations, and

"A great number of hospital-based physicians throughout the nation have declared their intention to bill separately for their professional services in keeping with this principle; therefore be it

"Resolved, That, since separate billing by the physician for his professional services is a preferred ethical practice, it shall be deemed unethical for a physician to displace a hospital-based physician who is attempting to practice separate billing when said displacement is primarily designed to circumvent separate billing."

The second resolution regretted that publication of Medicare Regulations No. 5 was delayed until June 28, three days before the effective date of Medicare, and said that these regulations do not conform to the intent of Congress as expressed in Section 1801 of the Medicare law. It then declared that:

"The House of Delegates instruct the Board of Trustees and the executive vice-president to request from the Social Security Administration an extension of date of final adoption of the proposed regulations of not less than 90 days, in order that the American Medical Association and all other interested medical organizations be al-

lowed reasonable time to study, and to submit, to the Social Security Administration data, views or arguments and pertinent constructive comments and suggestions.

"To preserve the professional independence of medical practice that the Board of Trustees and Officers of the AMA be instructed to immediately inform the membership that Medicare Reg. No. 5 will not apply to physicians (whether hospital-based or not) who

"1. have no financial relationship with a hospital covering medical services to patients

"2. do not accept assignments but bill directly

"*The AMA News* and other appropriate media be used to advise all physicians who are developing contractual relationships with hospitals for professional service that they should delay the finalization of any agreements pending further analysis of the implementing regulations."

Medical Ethics

In acting upon a board of trustees recommendation that a physician may participate in the ownership of a pharmacy or regularly dispense drugs, remedies or appliances or provide eyeglasses to his patients *only when approved by his component and constituent medical associations and when it is determined by them to be necessary in the best interests of the patient*, the House approved the following reference committee statement:

"The Principles of Medical Ethics provide: 'Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.' Your reference committee reaffirms the 1963 House of Delegates interpretation of the words 'in the best interest of the patient,' which reads as follows:

" 'It is the opinion of the Judicial Council that this language was adopted to permit both the practicing physician and the local medical societies to evaluate the many factual situations incident to prescribing and dispensing which are bound to arise in the practice of medicine. Under this language the doctor is permitted to exercise his own best judgment when caring for his patient. It is known that there will be situations when it is necessary or desirable for a physician to dispense or supply what he has prescribed. The Principles permit this to be done. On the other hand, this broad language provides a means by which a component medical society can inquire into the facts of a particular practice. The profession thus can act to prevent abuse of discretion and protect patients from exploitation. In essence this language means that a physician in the exercise of sound discretion may dispense 'in the best interest of his patient'; it does not authorize him to dispense solely for his convenience or for the purpose of supplementing his income.'

"The reference committee approves the goals sought by the board's report, but disapproves its specific recommendations. It notes that mechanisms presently exist for processing charges of deviation from the foregoing ethic and urges that these mechanisms be made vitally active at the local level. When charges of deviation develop, complaints should be made to the local society and vigorously processed by the appropriate committee of that society. If they are not resolved thereby, the complaints should then be carried to the state constituent association. The prudent physician will always seek the guidance of his local medical society in situations relating to ethical conduct."

The House directed the board of trustees to take action as expeditiously as possible to give wide dissemination to the reference committee report.

Discrimination

The House received six resolutions dealing with the subject of discrimination against some applicants for membership in component medical societies. It called attention to the strong position taken by the House in 1964 but pointed out that it is difficult to follow the 1964 directive because there is now no mechanism at the national level whereby a rejected applicant for membership at county or state level may obtain a hearing in order to right an alleged wrongful discrimination.

In lieu of the six resolutions, the House adopted a substitute resolution which directed the Council on Constitution and Bylaws to prepare such changes in the Constitution and Bylaws "as may be necessary to permit the Judicial Council to receive and act upon appeals filed by applicants who allege that they have been unfairly denied membership in a local and/or state society." The House asked the Council to report its recommendations at the 1966 Clinical Convention.

Health Manpower

On the subject of health manpower, the House received reports from the board of trustees, Council on Medical Education and Council on Medical Service and also one resolution. In general, all of them urged the AMA to assume leadership and mobilize its efforts to meet present and future shortages in health manpower. The House approved the board report, announcing appointment of a Committee on Health Manpower, and adopted the resolution. The two council reports were referred to the new board committee.

In taking these actions, the House approved a reference committee statement which included the following:

"Your reference committee is well aware of the drastic shortage of health manpower that is confronting the American public. It is keenly appreciative of the opportunity presented to the American Medical Association to furnish leadership in the solution of this problem. The necessary additional manpower in the medical profession and in allied health professions must be developed. The most effective and efficient utilization of existing health manpower must be made at all times. This is no time to surrender leadership to persons or organizations outside of the medical profession."

AMA Dues Increase

By a vote of 168 to 46, the House

approved an increase in AMA annual dues from $45 to $70, effective January 1, 1967, thus confirming a board of trustees recommendation which was given initial approval at the 1965 Clinical Convention.

The House, in approving the dues increase, accepted a reference committee statement which said:

"It is quite apparent that the programs necessary to serve the needs of the members of the association cannot be conducted effectively without adequate financing and it is equally apparent that such adequate financing is impossible without the dues increase requested by the board of trustees. Your reference committee reaffirms its confidence in the judgment of the board of trustees which has in the past and must in the future exercise the most careful and prudent stewardship over the assets of the association. The board of trustees is the committee elected by the House of Delegates to investigate and control the finances of the association. The appointment of any other committee to perform this function would be most inappropriate."

Other Actions

In considering 106 resolutions, 38 board reports and at least 20 additional reports from councils and other groups, the House of Delegates also:

Endorsed the **Declaration of Helsinki,** already adopted by the World Medical Association, as a guide to those who are engaged in clinical medical investigation;

Reaffirmed its opposition to the **compulsory assessment** of hospital staff members in order to raise funds for hospital construction;

Reconsidered its action in defining **usual, customary and reasonable** fees and referred the matter back to the Council on Medical Service for further study;

Urged all state and county medical societies to send representatives to the **Third National Congress on Medical Quackery** to be held October 7-8, 1966, in Chicago;

Commended the **American Medical Association Education and Research Foundation** for its accomplishments during the past four years and gave a standing vote of gratitude to Dr. Raymond M. McKeown, AMA-ERF president since 1962;

Strongly endorsed the **AMA Volunteer Physicians for Vietnam** program and urged the entire profession to support it by word and deed; approved a recommendation by the AMA survey team and the board of trustees that the association organize and administer a program of American assistance in **medical education in South Vietnam** supported by the U.S. Agency for International Development; was impressed by a report from Dean Pham Bieu Tam of the Faculty of Medicine, University of Saigon, and urged that the AMA do everything possible to assure that volunteer physicians caring for the South Vietnam civilian population are properly supplied with medicines and other medical supplies;

Adopted a resolution urging constituent medical associations to oppose, as detrimental to the public interest, any proposed legislation that would authorize **optometrists** to engage in the diagnosis or treatment of disease or injury of the eye;

Approved, with minor editorial revisions, a final report from the Committee on Maternal and Child Care of the Council on Medical Service dealing with the medical care aspects of **"Combating the Problems of Unwed Parents";**

Agreed with a strong policy statement condemning the **abuse of LSD** and other non-narcotic drugs, pointing out that the illicit use of LSD is subverting and vitiating important and necessary valid experimental studies, and recommending that the manufacture and distribution of LSD be continued as needed under strict control, with the drug being made available only to competent research workers (physicians trained in its use) on approval of the Department of Health, Education and Welfare;

Reaffirmed its opposition to the compulsory regulation of any **single** method, such as the use of generic terms, of the **prescribing of drugs;**

Offered AMA cooperation, in order to prevent public fear and misunderstanding, to those **foundations and other groups** which request it in clarifying statistical data, visual media and other forms of medical information to be presented to the public so as to provide an accurate view of the problems or problem with which they are concerned;

Adopted a humorous resolution and an equally humerous reference committee report which requested that "in the future full air-conditioning be considered as a prerequisite in the selection of the Headquarters hotel for the annual AMA Convention in those cities where the **psychophysiological effects of heat** may interfere with effective delegatemanship";

Received as information a comprehensive report on the **Relation of Medicine and Osteopathy,** which contains much material pertinent to future policy considerations, and also approved in principle a recommendation that doctors of osteopathy be commissioned in the Armed Forces Medical Services;

Agreed with a report recommending that the core curriculum plan for continuing medical education be *not* approved in its present form, that no further core curricula be developed at this time, and that various methods of continuing medical education be studied under the auspices of the Council on Postgraduate Programs;

Expressed its opposition to the **Hart bill,** S. 2568, and all similar legislation;

Adopted reports from the Council on Medical Service on a **Model Emergency Department Agreement** and on **Multiple Coverage in Voluntary Health Insurance;**

Approved board reports on **Exercise and Physical Fitness,** encouraging state and local medical societies to support the promotion of fitness programs, and on **Venereal Disease Control,** emphasizing the continued

need for all physicians to report all cases that come to their attention, and

Authorized the speaker of the House to appoint a **Resolutions Consultation Committee,** purely for editorial advisory purposes, at subsequent AMA conventions.

Presidential Addresses

Calling upon the medical profession for strength and unity in resisting the present socialist trend in this country, Dr. James Z. Appel of Lancaster, Pa., retiring AMA president, told the Sunday opening session that physicians "must participate in the ranks of both political parties and have a voice in the determination of party policy and the writing of party platforms."

Dr. Hudson, in his inaugural address Tuesday, declared that "we shall need all of our intellectual and scientific resources to cope with the new economics of medicine" and to prevent the extension of the Medicare program, without demonstrated need, toward a national health service.

Speaking at the final session of the House on Thursday, Dr. Hudson said that "a demonstration of our ability to perform must clearly indicate not only our competency in the field of medicine, but also our ability to react to a new kind of government thrust into health care." He warned that the real threat to our system of medicine is not in the details of Medicare implementation but in the expansion of the principle of social insurance.

Election of Officers

In addition to Dr. Rouse, the new president-elect, the following officers were named:

Dr. Jones as AMA vice-president; Dr. Walter C. Bornemeier of Chicago, speaker of the House of Delegates and Dr. Russell B. Roth of Erie, Pa., vice-speaker.

On the board of trustees, all for three-year terms, Dr. Homer L. Pearson of Miami, Fla., and Dr. Dwight L. Wilbur of San Francisco were re-elected; Dr. Burtis E. Montgomery of Harrisburg, Ill., was named to succeed Dr. Percy E. Hopkins of Chicago, who did not run for re-election, and Dr. Max H. Parrott of Portland, Ore., succeeded Dr. Raymond M. McKeown, who was not eligible for re-election.

For the Council on Medical Education, Dr. Kenneth C. Sawyer of Denver, Colo., was re-elected, and Dr. James W. Haviland of Seattle, Wash., succeeded Dr. Melvin W. Breese of Portland, Ore., who did not wish renomination.

For the Council on Medical Service, the House re-elected Dr. Charles J. Ashworth of Providence, R. I.; named Dr. Owsley to succeed Dr. Montgomery, and elected Dr. John R. Kernodle of Burlington, N. C., to replace Dr. Roth.

Dr. James M. Kolb, Sr., of Clarksville, Ark., was re-elected to the Council on Constitution and Bylaws. Named to the Judicial Council were Dr. Renato J. Azzari of New York City, to succeed Dr. Robertson Ward of San Rafael, Calif., and Dr. George W. Petznick of Cleveland, Ohio, to succeed the late Dr. James H. Berge of Seattle, Wash. ◄

F. J. L. Blasingame, M.D.
Executive Vice President
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AMERICAN MEDICAL ASSOCIATION CLINICAL MEETING
Date November 27-30, 1966
Place Las Vegas, Nevada

INDIANA HOSPITAL ASSOCIATION
Date Nov. 2-4, 1966
Place Marott Hotel, Indianapolis

NORTHERN INDIANA PSYCHIATRIC SOCIETY
Date Fourth Wednesday of every month, September through June
Place For location and program, inquire Beatty Memorial Hospital, Westville

INDIANA NEUROPSYCHIATRIC ASSOCIATION
Date Second Wednesday of the month, October through May, excluding December
Place The Athenaeum, Indianapolis

BONE AND JOINT CLUB
Date October 19, 1966
Place The Athenaeum, Indianapolis

INDIANA ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY
Date May 3-4, 1966
Place Stauffer Inn, Indianapolis

INDIANA PHARMACEUTICAL ASSOCIATION
Date July 18-20, 1967
Place French Lick Sheraton Hotel, French Lick

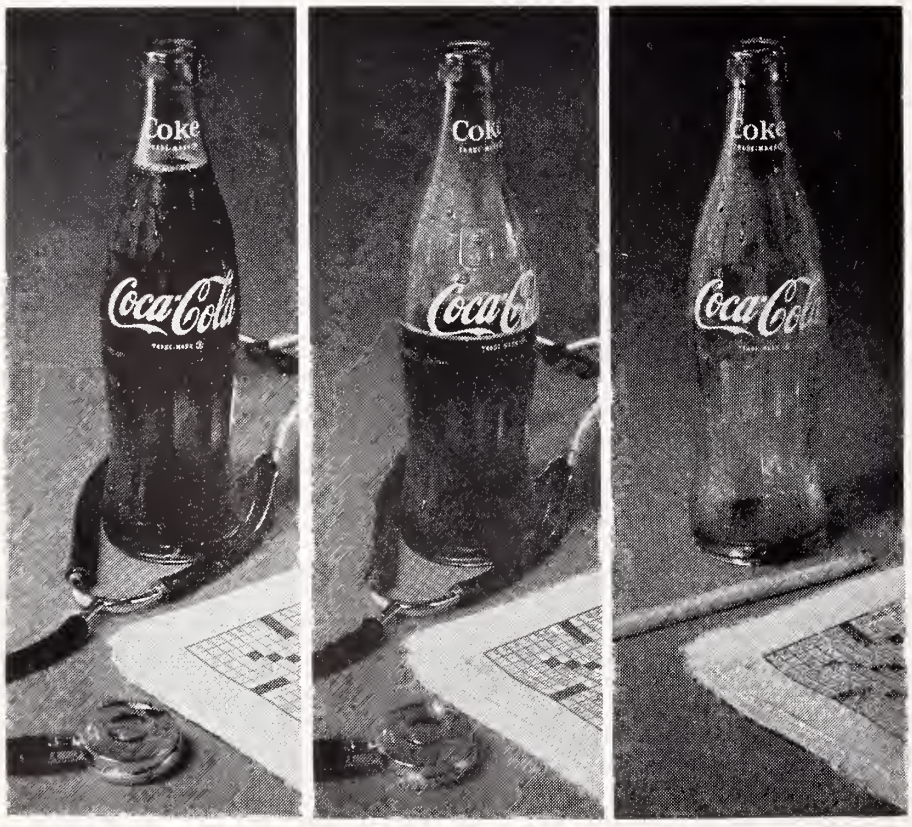
INDIANA ACADEMY OF GENERAL PRACTICE
Date May 3-4, 1967
Place Murat Temple, Indianapolis

INDIANA STATE MEDICAL ASSOCIATION CONVENTION
Date October 10-13, 1966.
Place French Lick, Indiana

INDIANA PUBLIC HEALTH ASSOCIATION
Date April 26-27, 1967
Place Indianapolis

INDIANA OBSTETRICAL AND GYNECOLOGICAL SOCIETY
Date November 2, 1966
Place Howard Johnson's (downtown), Indianapolis

INDIANA ROENTGEN SOCIETY
Date May 7, 1967
Place Indianapolis



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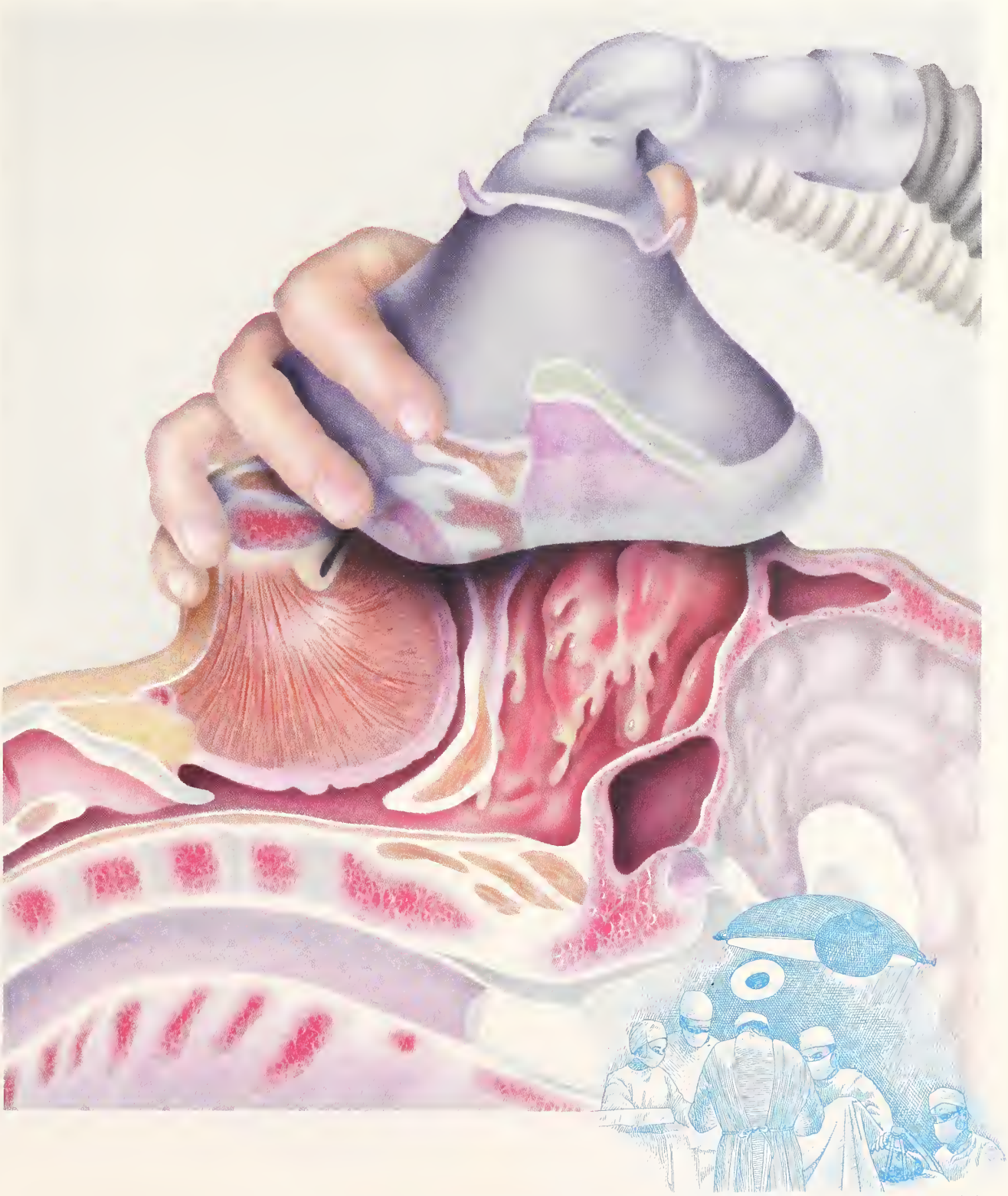
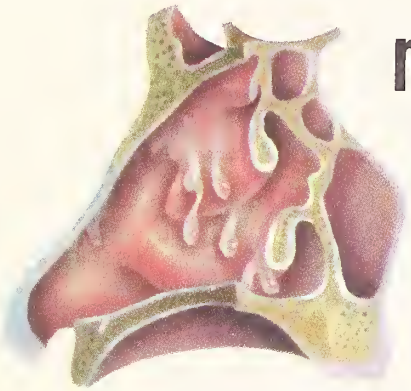


this issue: emergency anesthesia and the common cold

When emergency anesthesia is complicated by the common cold

Barry Belonsky, M.D., F.A.C.A.
Staff Anesthesiologist, Hospital of The Albert Einstein College of Medicine, New York City



Medical facilities are often presented with unfamiliar patients who have unknown health histories. This is particularly true in emergency situations that arise due to accidents or acute illnesses. These cases may need prompt care requiring anesthesia, and if they involve colds, nasal allergies or other upper respiratory infections, can account for many complications which make up a major hazard during emergency anesthesia.

Administration of general anesthesia to a patient with a cold or upper respiratory infection is a hazardous undertaking. It should be avoided if at all possible. Indeed, the presence of U.R.I. is good reason for postponement of elective surgery.[1] In emergency surgery, regional or local block should be considered, but if general anesthesia is mandatory, it should be approached with utmost caution.

Since the attitude of "emergency surgery — hurry" has been replaced by "emergency surgery — watch out",[2] a knowledge of the complications is a great help in preventing them. Here is a brief outline of the problems involved and their treatment. Prevention of the complications is discussed later.

Complications during the induction of anesthesia

Most of the complications are a direct result of secretions and some a result of accompanying secondary infection. For example, *airway obstruction* due to excessive secretions occurs very commonly and is the direct effect of the cold. Respiratory exchange may be obstructed at any time during anesthesia because of excessive secretions, but is most likely to occur during induction. Suction apparatus must be available to overcome this.[3]

Excess secretions which stimulate and irritate the epiglottis and vocal chords can cause *laryngeal stridor and obstruction*. This can lead to complete laryngeal closure with resultant anoxia and death.

Bronchospasm and laryngospasm can result from secretions penetrating the bronchi and bronchioles. In laryngospasm, there are both inspiratory and expiratory stridor and difficulty in inflating the chest; in bronchospasm there is an expiratory wheeze, but not as much difficulty in inflation, although some resistance may be felt. Stridor is due to partial or complete closure of the vocal cords in spasm and the "crowing" sound is almost pathognomonic.

Secretions obstruct the nasal airways. This produces *difficulty in ventilation* through the mouth until the patient is deep enough to place an oral airway. An intravenous agent can be given to facilitate the induction of anesthesia.

Difficulties can arise if intubation is performed to ventilate the patient. For example, teeth can be broken by too vigorous attempts at intubation, or the intubation itself may be technically difficult due to secretions obstructing the view of the glottis. The postoperative sequelae of intubation ranges from mild laryngitis to pneumonia with atelectasis, and are seen far more commonly in patients suffering from colds than in normal patients.

Successive stages of laryngospasm which produce the characteristic stridor or "crowing" sound.

Progression of bronchioles into bronchospasm.

Complications during the maintenance of anesthesia *Bronchospasm* can occur in an unintubated patient due to secretions entering the bronchial tree from above, and acting as an irritant to the bronchi and bronchioles. Secretions accumulate quickly and the patient has to be suctioned continually. The whole cycle of coughing, bucking, laryngospasm and bronchospasm may ensue. The difficult decision here is whether it is better to suction the patient continually or to use an endotracheal tube which protects the cords and bronchi but introduces the risk of attendant complications.

Postoperative complications Postoperatively, complications can be more serious than even the intra-anesthesia complications, and occur much more frequently in a patient who has been intubated.[4]

Sore throat and pharyngitis can result both from the preoperative upper respiratory infection and from the drying of the mucous membranes which occurs during anesthesia.

Tracheitis and bronchitis often result from secretions trickling down the tracheobronchial tree.

Laryngitis is frequently seen in patients with upper respiratory infections who have been intubated. There is a significant increase in the incidence of laryngitis compared to that in patients without upper respiratory infections.

Subglottic edema is a condition which occurs mainly in children who have been intubated. This pathology results from an exudate developing in the areolar tissue just below the cords. Because of the small size of the child's trachea, even a 1 mm increase in size of the mucous membrane can severely impair the air passage. Children exhibit this by severe expiratory stridor and may even become cyanotic. This may so severely embarrass the child's breathing that it must be treated vigorously. Most authorities agree on the treatment[5,6,7,8] consisting of a high oxygen concentration in the inspired air (60%), plus high humidity (close to 100%). Adequate parenteral fluid intake and slight cooling of the body temperature (by a cooled oxygen tent) also help in mild cases. In severe cases, there may be hypoxia which increases the restlessness and the oxygen demand rises. Sedation is often necessary, although concomitant depression of the respiratory center is undesirable. An antihistaminic accomplishes this purpose well, and adds sedation. Since there is always a possibility that an allergic response plays a role in edema, some relief of the respiratory distress may occur. Steroids should be used to control inflammatory and allergic phenomena and swelling. If all this fails, and the patient is still restless and hypoxic, a tracheostomy should be performed immediately.

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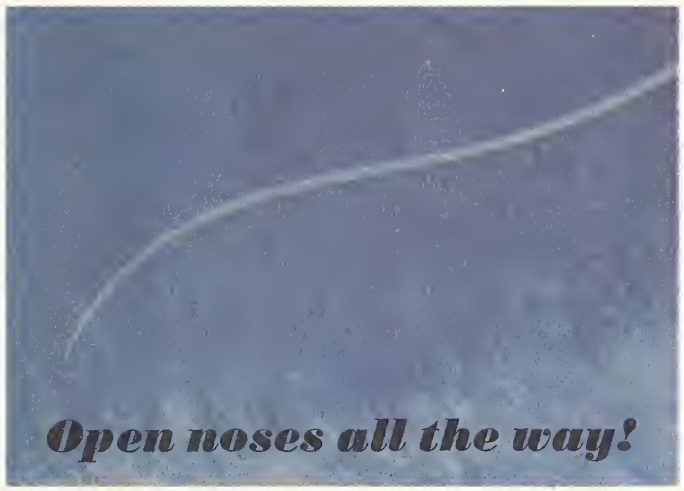

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Cross section of trachea showing subglottic edema and lumen reduction due to mucous membrane congestion.

Pneumonia may also follow anesthesia administered to a patient with a cold. This can be caused by accumulated secretions becoming secondarily infected and causing consolidation of the lung. *Atelectasis* of the lung can result if one of the bronchioles becomes plugged by secretions, preventing aeration of the distal part of that lung. This is seen more frequently following upper respiratory infection because dry anesthetic gases aggravate the infection, causing secretions to change from watery to thick and viscid, and consequently difficult to suction.

Prevention of complications

The first rule to prevent complications, of course, is to use a regional or local anesthesia whenever possible. But when emergency surgery is a must, in spite of the presence of a cold, allergy, or upper respiratory infection, here are some ways to prevent complications.

Give nose drops preoperatively. This can help shrink the congested nasal mucous membranes and reduce secretions for better air passage. (Results of this method are sometimes unsatisfactory because of the short duration of effect or rebound congestion.) For longer effect, oral antihistamines with nasal decongestants are often given to provide and maintain a drying effect on secretions.

To clear the tracheobronchial tree, instruct the patient to cough preoperatively. Cold steam or water nebulizers effectively humidify the nasal, pharyngeal and bronchial passages and often make the patient more comfortable. Tenacious secretions become more watery under humidification, clear more thoroughly preoperatively and are more easily suctioned from the airway during anesthesia.

Give intravenous fluids to those patients who appear dehydrated due to a cold. In a well hydrated patient the respiratory tract secretions are less viscid and more watery. This is particularly true in asthmatics.

Summary:

Administration of emergency anesthesia to a patient with a cold or upper respiratory infection can lead to a chain of events that may result in increased postoperative morbidity and even death. This is because of the excess secretions formed in these conditions. Preoperative measures to prevent or reduce these secretions should be undertaken and will result in smoother and safer anesthesia.

References

1. Ellis, G.: Anesthesia and the Common Cold, Anesthesia, 1955, Vol. 10, p. 78. 2. Smith, R. M.: Anesthesia for Infants and Children, 1963, p. 353. 3. Gillespie, Noel A.: Endotracheal Anesthesia, 1963, p. 155 et seq. 4. Smith, R. M.: Anesthesia for Infants and Children, 1963, p. 353. 5. Written, F. W.: Postoperative Laryngeal Stridor, British Journal of Anesthesia, 1966, Vol. 38, p. 73. 6. Snyder & Gants: Respiratory Obstruction at the Glottic Level, Anesthesiology, 1953, Vol. 14, p. 195. 7. Doming, M. V. & Oech, S. R.: Steroid and Antihistaminic Therapy for Postintubation Subglottic Edema in Infants and Children, Anesthesiology, 1961, Vol. 22, p. 933. 8. Gillespie, Noel A.: Endotracheal Anesthesia, 1963, p. 118.

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The Ideal Sport for Emotional Health: Lawn Bowls*

THOMAS N. DAVIS, III, M.D.
Hammond

I am pleased to have this opportunity to tell you about a participant sport which, in my opinion, is of value to health — both physical and emotional. It should be of interest to all physicians who are concerned about the effect of the lack of exercise in this age of physical inactivity. And it should be of particular interest to psychiatrists and others who are concerned about the problems which arise from the increasing leisure time in our society.

A few years ago my wife and I were invited to play lawn bowls. At first we had little interest in doing so, because the sport seemed rather dull, at least from the viewpoint of a spectator. But we noticed the players were obviously enjoying themselves, and so we tried it. After playing it a few times, I found it to be actually fascinating. And soon I also became intrigued by the seeming health benefits of the sport.

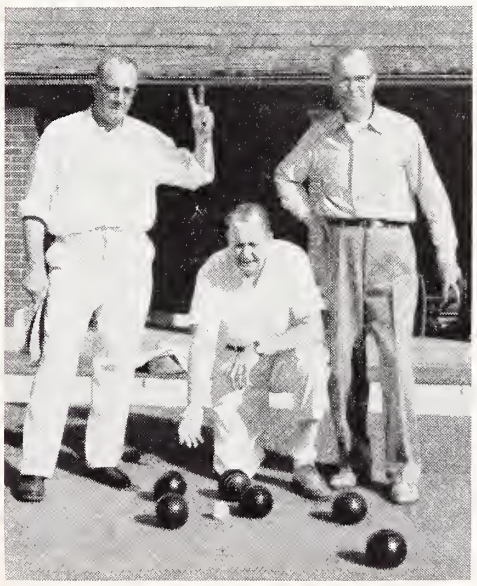
I frequently had the surprising experience of learning that such and such a player was five or even ten or more years older than what I had assumed! In other words, the lawn bowlers appeared significantly younger than their chronological ages. And I also noticed that most of the players seemed to be in excellent health. Even the ones who had had serious illnesses seemed to be going strong.

Strike at the Waistline

What was personally gratifying for me was that within a few months I lost 15 pounds of excess weight and three inches from my waistline; whereas I had gradually been becoming overweight. But in the three and one-half years since then, my weight and waistline have remained almost constant. Lawn bowls has helped my weight control in three ways: First, the exercise burns up calories. Second, the fun in playing the game has curbed a compulsive appetite (stemming from emotional tension). And third, the desire to do well in competition has motivated me to improve and maintain physical fitness. I take supplementary exercises when I can't lawn bowl regularly.

I tried to learn whether any scientific or clinical studies have been made which would support, or negate, these impressions about the health of lawn bowlers. I was unable to find any such studies. But I did learn that for centuries many enthusiastic opinions have been expressed to the effect that lawn bowling contributes to health, longevity and well-being. The records of such opinions go back as far as Francis Bacon (1561-1621) and Shakespeare. The latter in "Richard II" had the sport recommended to the Queen — she had what today would be diagnosed a depressive reaction, precipitated by her husband's being away at war.

I also learned that whenever there has been an enlightened attitude about mental illness, sports as well as other forms of recreation have been used as part of therapeutic programs. For example, Celsus, a Roman physician in the time of Julius Caesar, used them as well as other modalities. And in the nineteenth century, "moral treatment," as it was called then, was used in the better mental hospitals. It consisted of sports and other activities which later came to be called occupational or recreational therapy.



JOHN CORDES signals to skip in a game of lawn bowls — he is laying two shots up. George Madden (on one knee, center) gives his team skip instructions on how to come in to get a shot as Phil Sheridan, disgusted, signals his team is two shots down. All are members of the Lakeside Lawn Bowling Club.

Aggressive Transferral

What is the rationale in the use of sports in treating the mentally ill? According to Helene Deutsch, the psychoanalyst, sports are an ideal medium for mastering inner fears by projecting them onto the outside world. Several psychiatrists, including Karl Menninger, Harry Stack Sullivan, and Robert A. Moore, have emphasized that sports enable inner tensions and conflicts — especially hostility and excessive aggressiveness — to be relieved. As Menninger has put it, "We do not keep patients playing tennis just to keep them busy, but to enable them to return their aggressions outward and thus to relieve their need for expressions of internal aggressions."

Paul Haun and others have emphasized that play or having fun is a basic human need. This viewpoint is at least as old as Plato and is implicit in the saying "All work and no play makes Jack a dull boy." Others have pointed out the importance of keeping in balance such activities as work and play, frustration and gratification, effort and relaxation. Enhanced self-esteem and improved social or interpersonal relations are other benefits attributed to participant sports.

Lawn bowls — also known as bowls or bowling-on-the-green — is an entirely different sport from ten pins and

*Presented at the Northern Indiana Psychiatric Society Meeting, Gary, March 23, 1966.

all other bowling games. Although it is not generally well known in the United States, it is one of the most popular participant sports in most English-speaking countries. In Scotland, for example, it is even more popular than golf. And in sports-loving Australia, it has gained in popularity more rapidly than any other sport or pastime since World War II. In this country it is becoming popular in resort areas like Florida and California. At this time, the only bowling green in Indiana is in Gary. Nearby cities with greens include Chicago, Cincinnati, and Niles, Michigan.

These are the principal features of lawn bowls:

First, it is played out-of-doors in fresh air.

Secondly, there are no pins as in alley bowling. The target is like a billiard ball and is called the "jack." As in horseshoes, the object is to get closer to the target than your opponent. Each ball (called a bowl) closer to the target than your opponent's scores one point. Theoretically, as many as eight points can be scored at one time in a team game, or four in a singles competition. But in a well-played game, only one or two points are usually scored at one time.

Third, play alternates back and forth from one end to the other of a grass playing surface 40 yards long. Consequently, after a player delivers his bowls (or balls), he walks a minimum of 40 yards, thus exercising his legs. Also, picking up bowls from the ground and delivering them exercises abdominal muscles as well as the arms.

Fourth, the bowls are only about five inches in diameter and weigh a little over three pounds. They are easily handled, even by handicapped and infirm persons.

Fifth, and one of the most important features of the sport, the bowls are not perfect spheres but are slightly lopsided or "biased." As a result, they do not roll straight but in a curve. A bowl rolling about 100 feet may deviate to one side as much as four or five feet or more, depending upon its exact shape and weight, the method it is delivered and the quality of the playing surface. This feature, which dates back at least four centuries, not only makes lawn bowls unique as a bowling game but adds to its fascination. It requires greater skill to deliver a bowl near the target. A bowl can be delivered too far or too short, as well as too much to either side.

Strategy Rivals Chess or Bridge

The biased shape adds considerable variety to the sport. There are many ways a player can try to outmaneuver his opponent. In fact, if he simply tries to deliver his bowls close to the jack — and succeeds — then he is apt to learn to his regret that he has set up an easy target for his opponent. With enough skill — and luck — he can make the bowl curve in from the right side, or from the left. He can knock away an opponent's bowl. He can nudge closer a previously delivered bowl. He can put in a "blocker" to protect a good shot. He can even knock the jack to a more favorable position! And so forth. The sport has so much variety of play that it rivals chess as a game of strategy.

The element of chance or uncertainty also plays an important part. It resembles a card game like bridge in this respect. For example, the jack may be hit, and where it goes can make a difference of several points for one side or several for the other. The most successful strategy in bowls anticipates the different possibilities that can occur.

Bowls has a history that is almost as fascinating as the sport itself. It is very ancient in origin. It was so popular in England by the fourteenth century that it interfered with the practice of archery, which was the principle defense of the realm, and it was prohibited by statute. But the kings and upper classes continued to enjoy it while prohibiting it from the common people.

At other times it fell into disrepute because of its association with taverns and betting. The sport became increasingly popular in Scotland, where were developed the code of laws and traditions that form the basis of the way the game is played today. The most famous game in history was that of Sir Francis Drake, who insisted upon finishing his game of bowls before fighting the Spanish Armada in 1588. Bowls was also popular in colonial America, and several towns, including one in Indiana, still have the name of "Bowling Green." But the sport died out with the Revolution because of anti-British sentiment.

In 1768 a hospital in Edinburgh gave land "so that an exercise so beneficial to the health of the inhabitants might not be totally lost for want of proper bowling greens." The modern popularity of bowls in England dates back to the turn of this century. At that time, Dr. W. G. Grace, a physician and famous cricket player, who was in charge of sports at the Crystal Palace in London, converted grass tennis courts into bowling greens.

Enjoyment and Therapy

Today in Britain and the Commonwealth countries, many physicians play bowls and recommend it as a healthy recreation and exercise. And it is used at many hospitals in Britain, Canada and elsewhere as a part of therapeutic programs. For example, eleven psychiatric hospitals in western Scotland have a league in which weekly interhospital matches are held. I visited one of these, Ailsa Hospital in Scotland. It has its own bowling green, and the staff is enthusiastic about the patients' response to bowls. In Canada two of the hospitals having lawn bowls are Sunnybrook in Toronto and Westminster in London, Ontario. And in the United States, the sport is used at the Veterans Hospitals in Wood, Wisconsin, and in Northport, Long Island. Doctors at these hospitals and elsewhere have expressed favorable opinions about the benefits from playing lawn bowls.

As to physical health, the consensus is that the sport provides non-violent, non-jerky exercise — especially of the

DR. RALPH G. BENGSTON, Chicago, on the mat, has just delivered a bowl at the Lakeside Lawn Bowling Club, Jackson Park, Chicago. Dr. Bengston is a member of the South Shore Country Club, who was playing the Lakeside team.—Photos by Joe Ibe, Chicago.

legs and abdomen as well as the arms. Dr. Murray Blair, a physician of Vancouver, B. C., has particularly emphasized the importance to physical fitness of exercise of the legs, and of lawn bowls providing this kind of healthy exercise. As to emotional health, these are the most frequently reported features: pleasant relaxation, lack of excessive tension, boosting of morale, and the patients' continuing interest; also, competition and self-esteem, and the improved interpersonal relationships, including cooperation.

Thus there has been, and is, considerable opinion about the value of lawn bowls to emotional, as well as physical, health. And now I would like to give some requirements of an hypothetically ideal sport for enhancing mental health and emotional well-being, and to discuss the extent to which bowls meets these requirements.

It Must Be Fun

A first requirement of a sport for enhancing emotional health is that it be fun. Lawn bowls fully meets this requirement, for it is fun for millions of enthusiastic devotees in the countries and areas where it is known. It can be fascinating for people who need relief from pressing responsibilities. Walt Disney, the film maker, is an example of a man very active in business life who delights in playing bowls. Bowls likewise can be fascinating for persons who might otherwise be idle, such as retired persons.

What makes it fun? There are several factors, not even taking into account its being played outdoors in participation with other people. It is a challenging skill that can never be completely mastered. According to the belief of a famous British player, A. T. Evans, it takes ten years to become a *good* bowler, though a reasonable standard can be learned in two or three years. The variety, the strategy and the uncertainty or chance, which have been discussed above, contribute to the fun. Upsets frequently occur; there is rarely a "sure win," not even by experts.

A second requirement of an ideal sport for enhancing emotional health is that it be a participant rather than a spectator sport. Since bowls is not a strenuous sport — at least when not played too much at one time — it can be played by almost all age groups and even by handicapped and infirm people. I have seen a 92-year-old man play a keen game, and on the same green with a 16-year-old! I met a Canadian lawn bowler who had played the sport for 75 years — since the age of nine! I have seen persons lawn bowl who have had coronaries, strokes, multiple sclerosis, slipped disks and other afflictions.

A third requirement is that it afford healthy exercise. As discussed above, lawn bowls provides non-jerky, non-violent exercise of the legs, abdomen and arms, and in keeping with the kind of exercise recommended by many cardiologists. Dr. Paul Dudley White has written "I heartily agree with you concerning lawn bowls. I wish I had time to play it myself. It certainly is a very relaxing and pleasant game and I am heartily in favor of it. But I am also in favor of the Italian "boccie" which can be played on practically any surface."

An increasing number of physicians are recommending exercise as preventive medicine, and even as treatment. But many, including myself, doubt that a regime of exercise can continue successfully very long unless it is fun. An Australian heart researcher, Dr. Salek Minc, has found that exercise done without the heart "being in it," so to speak, can strain the heart. Injuries from playing lawn bowls are virtually non-existent.

Meeting Emotional Needs

A fourth requirement of a sport that is ideal for enhancing emotional health is that it meet the emotional needs of its players. The fun from playing lawn bowls has been discussed above. Another important emotional need that can be met from participation in sports is the discharge of aggressiveness and competitiveness. In bowls, aggression is not spectacular to the uninitiated eye. But on a symbolic level it can be fierce! In fact, the symbolic interaction or conflict is a feature that is

not present in some sports such as alley bowling and golf. In these, a player competes with himself, in a sense, rather than with opponents. I know of no sports experience that is more exhilerating than playing bowls against a skilled opponent who has delivered bowls to advantageous positions, and your knocking his bowls away to change a probable big score for him into a score for yourself! And by the way, it has been said that bowls is the oldest game played in which missiles are used!

But bowls is not only a medium for competition but also one for cooperation. It is an excellent team game calling for team play and harmony. Teams are made up of two, three or four players. The "skip" or last member of the team to bowl is like the quarterback in football — he directs the play of his teammates. He needs not only to have the technical skills but also to be a master of strategy. And he especially needs those qualities of leadership which inspire harmonious team spirit.

Among the other emotional needs that can be met in playing lawn bowls are self-esteem and recognition. Winning applause from teammates can be very gratifying, especially when a trophy or title is at stake. The average, or below average, player has a better chance of upsetting the experts than in many sports. Conversely, it is relatively easy for a player to rationalize his losses if winning is important to his self-esteem.

If any sport provides opportunity for self-understanding, then lawn bowls does. This is so because of the importance of a player's concentration in his being competitively successful. Regardless of his technical skill, his success depends in part upon his subjective or emotional state. And his playing thus provides an indication of any inner tensions.

Bowls certainly provides an opportunity for understanding others, at least certain aspects of their personalities. A. T. Evans' book, *Competitive Bowls,* has a chapter entitled "Sizing Up Your Opponent." He says that successful bowls is assisted by a study of men, and that in bowls you can form a fairly accurate judgment of a man's character. He describes a number of personality types that a bowler is apt to meet.

A fifth requirement is that it be a group activity. I have already described some of the interpersonal aspects of bowls, including competitiveness and cooperation. There are others too. For one, no sport has a stronger tradition of sportsmanship and of amateurism. For centuries it was played only by royalty and upper classes, and in many respects it is still a gentleman's game. Arguments are very rare. Razzing and jeering are strictly taboo. This tradition serves well to keep aggressiveness from becoming excessive, and thus it helps to minimize strained relations and guilt feelings.

Ideal for Clubs, Families

Bowls offers more opportunity of social contact and camaraderie than most sports. For example, in a tournament played by teams of four, a player has opportunity to socialize not only with his three teammates but also with several teams of opponents. In addition, he can see something of the players in near-by games, and still others during a coffee break. Bowls makes an ideal family sport. Many fathers and sons play together as a team, as do husbands and wives. Indeed, it can be said that lawn bowls is the treatment of choice, and the prevention, of the affliction, "golf widowhood!"

The playing of bowls is often organized on the basis of clubs, and these offer additional satisfying activities, such as organizing tournaments, serving refreshments, taking care of the clubhouse, the greens, and so forth. A bowling clubhouse that has been described as the most fabulous one in Britain was built by the members' own labor! A patient at Westminster Hospital in London, Ontario, recovered from a mental illness, expressed the opinion that his working on the bowling greens there did as much as anything else in his recovery.

A sixth requirement of the ideal sport for emotional health is that it be adaptable to different gradations of involvement by its players. Lawn bowls meets this requirement, both in physical and emotional aspects. It can be played very leisurely and socially. It can be no more than an excuse to get outdoors with other people. And it can be played as seriously as any other competitive sport. It can be played in slow motion or in quick motion. Singles games are particularly suitable to the very competitive player, as is the position of "skip" in a team game. Other positions in a team game are less demanding, especially "lead" or first.

A seventh requirement is that there be opportunity for playing it. In countries where bowls is popular, good greens are common. In the area of Glasgow, Scotland, for example, there are some two hundred or more. The amount of space needed for a full-size green, about 42 by 42 yards, is roughly about the same as that needed for three tennis courts. This means that the space serving a maximum of 12 tennis players at one time could serve as many as 64 lawn bowlers at one time. Also, it is relatively easy to light up a green for night play.

These, then, are some of the many advantages of lawn bowls as a sport in aiding health in general and emotional health in particular. Does it have disadvantages? Its only major disadvantage is its dependence upon good greens, which require expert know-how for their construction and maintenance. Without good greens, the sport can be very disappointing. It is recommended that anyone planning to construct a bowling green communicate with the American Lawn Bowls Association. Its secretary is John W. Deist, 1525 Ridge Court, Wauwatosa, Wisconsin 53213.

The experience of one lawn bowls enthusiast is well worth reporting. Upon moving to Fresno, California, he felt very disappointed that no greens were available. And so in January of

1964 he put down a green on his own lawn! It measures 26 by 90 feet. And he organized a lawn bowls club. Since then, he has reported that the number of members in the club is steadily growing and that the Fresno Park Department is now opening a green. And also, other organizations there are considering putting down greens.

Summary

Lawn bowls is a participant sport that is entirely different from any other bowling game. For centuries it has been considered of value to both physical and emotional health. It provides non-violent, non-jerky exercise — especially of the legs, as well as the abdomen and arms. It can be played by almost all age groups and by handicapped and infirm persons. It can be a fascinating activity, both for people who need relief from pressing responsibilities and for people who might otherwise have little to do. It is capable of meeting many emotional needs, including the release of excessive tensions, competition, self-esteem and cooperation. It provides more opportunity for social contact and camaraderie than do most sports. And it is adaptable to different gradations of involvement by its players.

Lawn bowls can help to answer the problems created by a lack of physical activity and by increased leisure time. Physicians who play lawn bowls find it fun — and beneficial to health, both as preventive medicine and as treatment.

Acknowledgement

Isabelle B. Davis, M.S.W., A.C.S.W., gave valuable suggestions and helped in the preparation of the manuscript. ◄

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ABSTRACTS

BOOK REVIEWS

THE PHARMACOLOGICAL BASIS OF THERAPEUTICS

Edited by Louis S. Goodman and Alfred Gilman, 3d edition, New York, MacMillan Co., 1965; 1785 pages; numerous figures; $22.50.

This third edition of "Goodman & Gilman" (with 42 co-authors) positively vibrates with lucid, compact, up-to-date expositions of information geared for every level of the medical profession: from the student cramming for an exam all the way to the very top consultant seeking an immediate answer to a specific therapeutic problem.

There will be long and ecstatic reviews of this work. Suffice it to say that this volume belongs on the working shelf of every doctor, wherever he may be. Within a scant 25 years, it has become, at the very least, the equal of many famous texts that have preceded this monograph in its chosen field.

The publisher has used good paper and excellent binding; the printing is easy on the eye and (in my spot-checking) I've yet to encounter as much as a single typographical error! *Everybody* connected with this book has labored long and well! We doctors can only congratulate them on their product: and proceed to make daily use of their superb achievement!

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New York, N. Y.

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PHYSIOLOGY AND BIOPHYSICS

Ruch & Patton, 19th ed. of Howell's *A Textbook of Physiology for Medical Students and Physicians,* W. B. Saunders Co., Philadelphia, Oct., 1965; 1242 pages; illustrated; $17.00.

The preceding edition still used the word "medical" in the title. In this revision they have dropped this word: it is simply "Biophysics": "the physics and physiochemistry of the organism." In line with this continuing transformation, only a scanty 1/3 of the two dozen authors have an M.D. after their names. The medical student is getting his physiology in ever "purer," basic scientific presentation. The editors are frank in saying that "this is not an easy textbook for students."

Now I admit that I acquired a Ph.D. in physiology after my M.D. — many years ago. Still, the knowledge explosion makes it ever more difficult to keep up a smattering of the newer information being presented. Attending the FASEB convention recently, I had the privilege of listening to a professor of aerophysics develop the mathematics of just what happens when blood flow through a capillary is subjected to rigorous analysis. Did you know that it takes six *hours* for one cc. to pass through a single capillary channel?

Well, regardless of whether we approve or disapprove, today the circulation system is treated as a control mechanism in its fullest engineering meaning. Will this approach make for better doctors? All we can say is "Let us hope so." I rather think that the task of the *clinical* preceptors is being made ever more complex. We fail to teach the personal, human, individual factors at the peril of losing our most precious asset: the confidence of the patient in *his* physician.

Regardless of these philosophical comments, this continues to be a most competent, superb, as contemporary-as-possible textbook of physiology: the peer of any in the field. Errors are few; thus, on page XII of preface, the word should be "consensus" not "concensus." This solecism in no way detracts from the flow of thought. The printing is splendid; the binding, excellent. In *JISMA* issue of Sept., 1961, I had had the pleasure of reviewing the preceding edition. If anything, the high standards are being exceeded in the present effort. The serious reader will get from this volume an overall-view of physiology that will amply reward him for the many hours he puts into the slow digestion of the abundant fare presented.

ARNOLD LIEBERMAN, M.D.,
New York, N. Y.

Abstracts From Various Literature, Prepared by AMA

ACUTE CHOLECYSTITIS AS A COMPLICATION FOLLOWING SURGERY UNRELATED TO THE BILIARY TRACT

J. E. Strode (Straub Clinic, Honolulu)
Surgery 59:195-198, (Feb.), 1966.

The possibility that the gallbladder may be diseased increases with the age of the patient. When symptoms develop from acute cholecystitis in the postoperative period of surgery for conditions other than in the biliary tract, the symptoms may be atypical. If prior to surgery the patient has had symptoms suggestive of gallbladder disease, or the gallbladder is known to have failed to be visualized, or gallstones have been demonstrated, one should be much more alert to such a complication as cholecystitis developing. Pain and tenderness over the right upper quadrant of the abdomen associated with fever and leukocytosis are the cardinal findings in cases of acute cholecystitis, but in the postoperative period, particularly after an abdominal

operation, the patient may have widespread pain and tenderness associated with distension, making the recognition of cholecystitis difficult. The abdomen should never be closed, leaving a diseased gallbladder in place without giving due consideration to the potential possibilities of serious complications that may develop.

APLASTIC ANEMIA ASSOCIATED WITH INSECTICIDES

H. J. Woodcliff (Royal Perth Hosp., Perth, Australia), P. M. Connor, and J. Scopa

Med. J. Aust. 1:628-629, (April 9), 1966.

Two cases of aplastic anemia associated with exposure to chlorophenothane (DDT) and benzene hexachloride are reported. The first patient, a 39-year-old woman, had washed her dog once a week over a two-year period in a preparation containing 2% benzene hexachloride. The second patient had used a garden spray containing 20% DDT and 5% lindane.

CHROMOSOME ANALYSIS OF HUMAN AMNIOTIC FLUID CELLS

M. W. Steele and W. R. Breg, Jr. (Yale University School of Medicine, New Haven, Conn.)

Lancet 1:383-385, (Feb. 19), 1966.

Human amniotic fluid has been shown to contain viable cells that will grow in culture, in sufficient quantity to be karyotyped. The epithelioid morphology of these diploid cells supports the contention that they are derived from the amnion and are, therefore, fetal in origin. Chromosome analysis of the fetus in utero is thus feasible. An improved technic for the reliable determination of intrauterine fetal sex chromatin is described. Of the 21 babies in the study, born so far, the prediction of the fetal sex has been accurate in all cases. In the 14 boys, the fetal sex chromatin ranged from 0% to 2%; in the seven girls it was between 12% and 34%. One case showed an intermediate value (6%), but the neonatal sex of the baby, which was stillborn, is not known.

DELAY IN DIAGNOSIS OF CARCINOMA OF RIGHT SIDE OF COLON IN PATIENTS TREATED FOR ANEMIA

L. Fass, F. W. Anderson, and L. E. Young (260 Crittenden Blvd., Rochester, N. Y.)

Amer. J. Med. Sci. 251:255-259, (March), 1966.

Of 303 cases of carcinoma of the right colon reviewed in two hospitals, 37 were found to have been treated for anemia without proper diagnostic evaluation for one month or more. This group of 37 patients did not differ from the untreated group with regard to private or nonprivate classification, hospital service, age, color or extent of disease. There was a significantly higher proportion of females in the treated group. Physicians were diligent in investigating ill-defined symptoms possibly related to anemia. Treatment of anemia in all 37 cases was prescribed by physicians, and no self-medication was incriminated in the delay in diagnosis.

CHEMOTHERAPY OF HODGKIN'S DISEASE

D. A. Karnofsky (Sloan-Kettering Institute, New York)

Cancer 19:371-377, (March), 1966.

Radiotherapy has the first priority in planning an appropriate therapeutic program for the patient with Hodgkin's disease, but chemotherapy has also acquired an important role. Drugs which have demonstrated therapeutic activity in Hodgkin's disease include polyfunctional alkylating agents, vinca alkaloids, N-methylhydrazine, adrenal steroids, and actinomycin D. The antimetabolites have been less successful; an irregular and brief effect is reported for methotrexate, and generally no benefit at all from 6-mercaptopurine and 5-fluorouracil. The indications for drug therapy include: (1) localized Hodgkin's disease treated in combination with x-ray therapy; (2) acute situations when rapid relief of signs or symptoms are necessary and (3) wide-spread disease with systemic manifestations. There are no certain guides to the choice of drug or regimen, and the therapeutic program in each case must be adapted to the patient and to the treatment modalities available in order to achieve the best results in survival time and comfort of the patient.

POSSIBILITIES FOR THE CURE OF HODGKIN'S DISEASE

E. C. Easson (Christie Hospital and Holt Radium Institute, Manchester, England)

Cancer 19:345-350, (March), 1966.

Analysis of over 1,000 cases of Hodgkin's disease treated at the Christie Hospital in Manchester, England, from 1934 through 1959 with a consistent treatment policy shows that, of those with clinically localized disease (slightly more than one-third of the total), more than 50% survived five years and about 40% may be expected to survive 15 years. Evidence shows that survivors beyond ten years should be considered cured. The treatment policy for these apparently localized cases is described, and consisted of radical irradiation of the involved anatomical region. Lymphosarcoma and reticulum cell sarcoma cases, as well as a group of lymphoma patients in whom the histological classification was equivocal, were managed in the same way and the survival rates are slightly better than those for Hodgkin's disease. The general attitude of pessimism based on the idea that Hodgkin's disease is incurable seems unwarranted and harmful in that it tends to come between the patient and the early choice of the most successful therapy.

Continued

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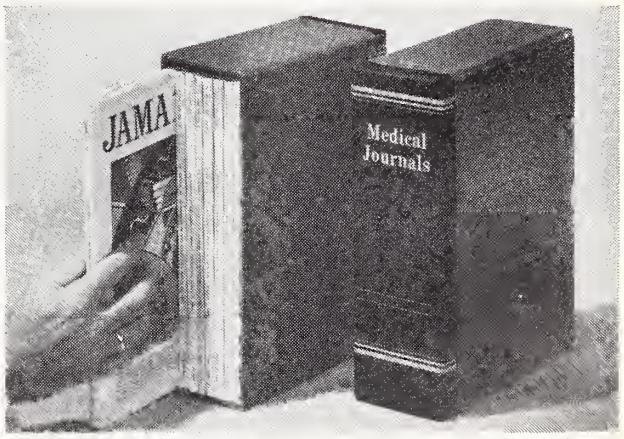

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CURRENT ATTITUDES ON DIVERTICULITIS WITH PARTICULAR REFERENCE TO COLONIC BLEEDING

B. M. Rigg (Nuffield College, Lincolns Inn Fields, London) and M. R. Ewing

Arch. Surg. 92:321-332, (March), 1966.

After reviewing the literature on colonic bleeding associated with diverticulitis, there seems to be good evidence to support the statement that diverticulitis of the colon may be the cause of massive colonic bleeding. Mild colonic bleeding may be the result of diverticulitis, but a diligent search must be made for other possible causes such as polyps or carcinoma. It is believed that diverticulitis is responsible for mild colonic bleeding in no more than half of the commonly reported incidence of 15%. The management of massive hemorrhage from diverticulitis should be conservative, whereas a more energetic diagnostic approach should be undertaken particularly in the group with mild bleeding. Exploratory laparotomy may often be advocated in the treatment of this group.

PROGRESS IN TETANUS PROPHYLAXIS: THE ADVENT OF HUMAN ANTITOXIN

B. J. F. Perey (Royal Victoria Hosp., Montreal)

Canad. Med. Assoc. J. 94:437-441, (Feb. 26), 1966.

Injections of tetanus antitoxin of animal origin frequently cause serious disability and sometimes death. Despite world-wide knowledge of these effects, millions of prophylactic injections of equine tetanus antitoxin are given annually; and proposals persist to increase the dosage to obtain higher protective levels in the serum, a procedure which would increase the incidence and severity of reactions. Furthermore, equine antitoxin frequently fails to prevent tetanus. Tetanus antitoxin of human origin, which carries no risk of complications, more quickly confers a higher degree of immunity than equine antitoxin. The cost of treating reactions to horse serum, together with the financial loss incurred by work absence, far outweighs the cost of human antitoxin. The use of antitoxin of animal origin is no longer medically or legally defensible.

TRANSFUSION OF LEUKOCYTES FROM DONORS WITH CHRONIC MYELOCYTIC LEUKEMIA TO PATIENTS WITH LEUKOPENIA

E. E. Morse et al. (Medicine Branch, National Cancer Institute, Bethesda, Md.)

Transfusion 6:183-192, (May-June), 1966.

Leukocytes were collected from donors with chronic myelocytic leukemia by plasmapheresis and transfused into severely leukopenic recipients. The median transfusion of 7 X 10^{10} granulocytes (range .15 to 35 X 10^{10}) resulted in a median increase in circulating granulocytes of 1,000 per cu mm (range 0 to 19,000) one hour after injection. The posttransfusion increment was directly related to the number of cells injected. Only 4.8% of the injected cells were removed in the circulating blood volume at one hour (range 0-37%). The percent recovery was directly related to the pretransfusion granulocyte count of the recipient; the more severe the recipients' leukopenia, the lower was the percent recovery of transfused cells. The transfused granulocytes disappear from the recipients' circulation with a half-life of 24 hours. Clinical responses as measured by disappearance of fever were seen in 54% of the recipients. The fraction of febrile patients responding increased as the dose of leukocytes increased. ◄

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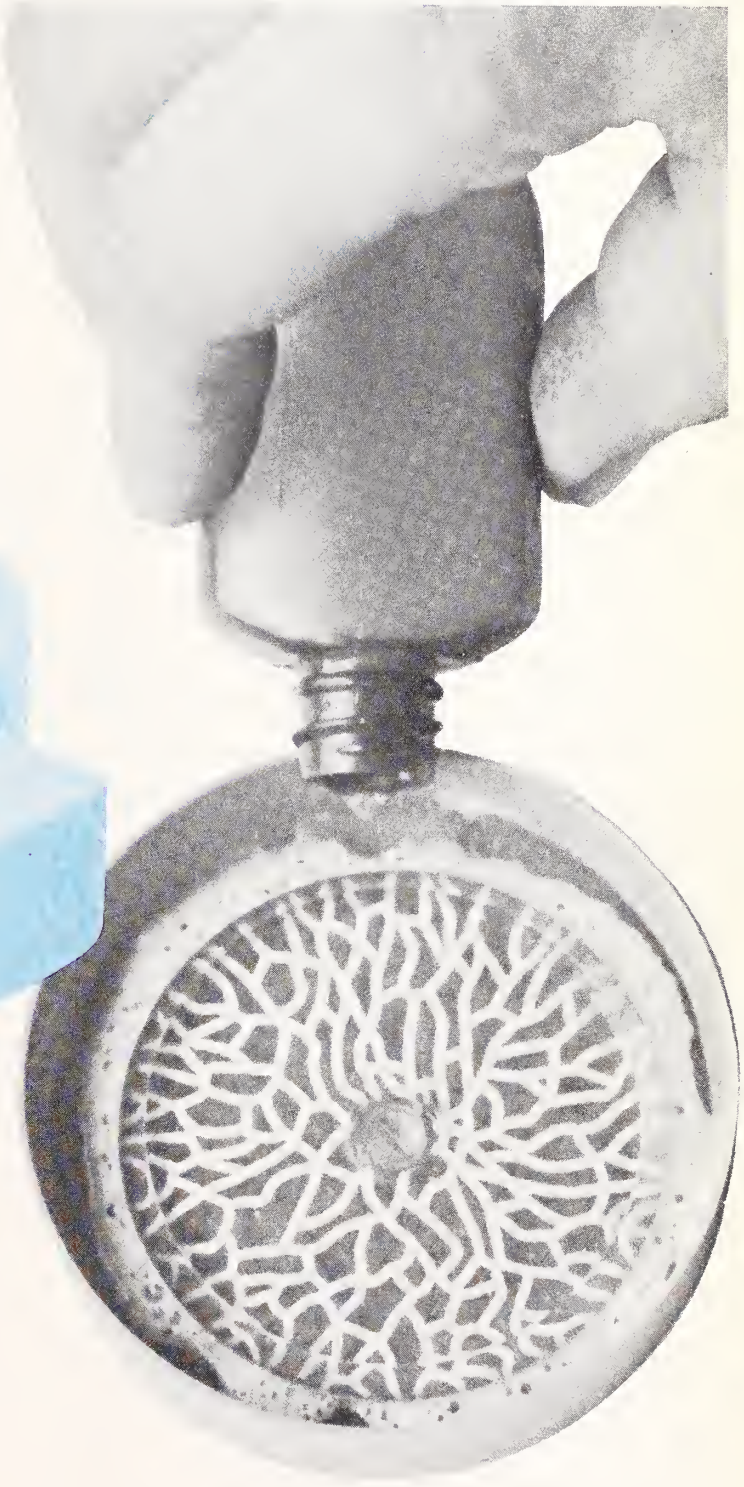

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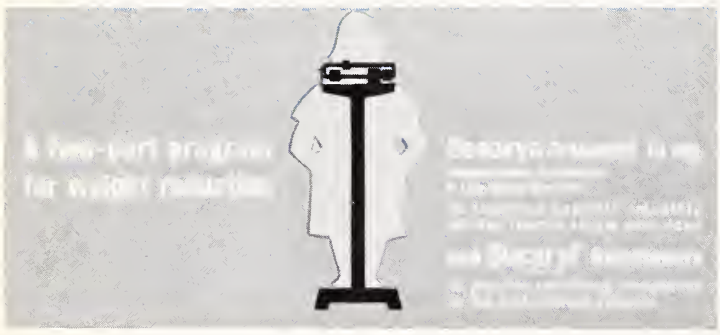

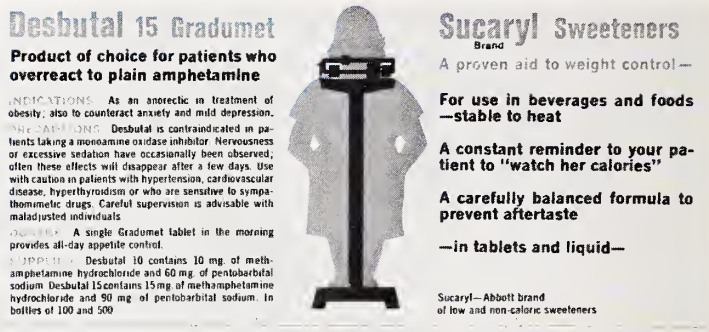

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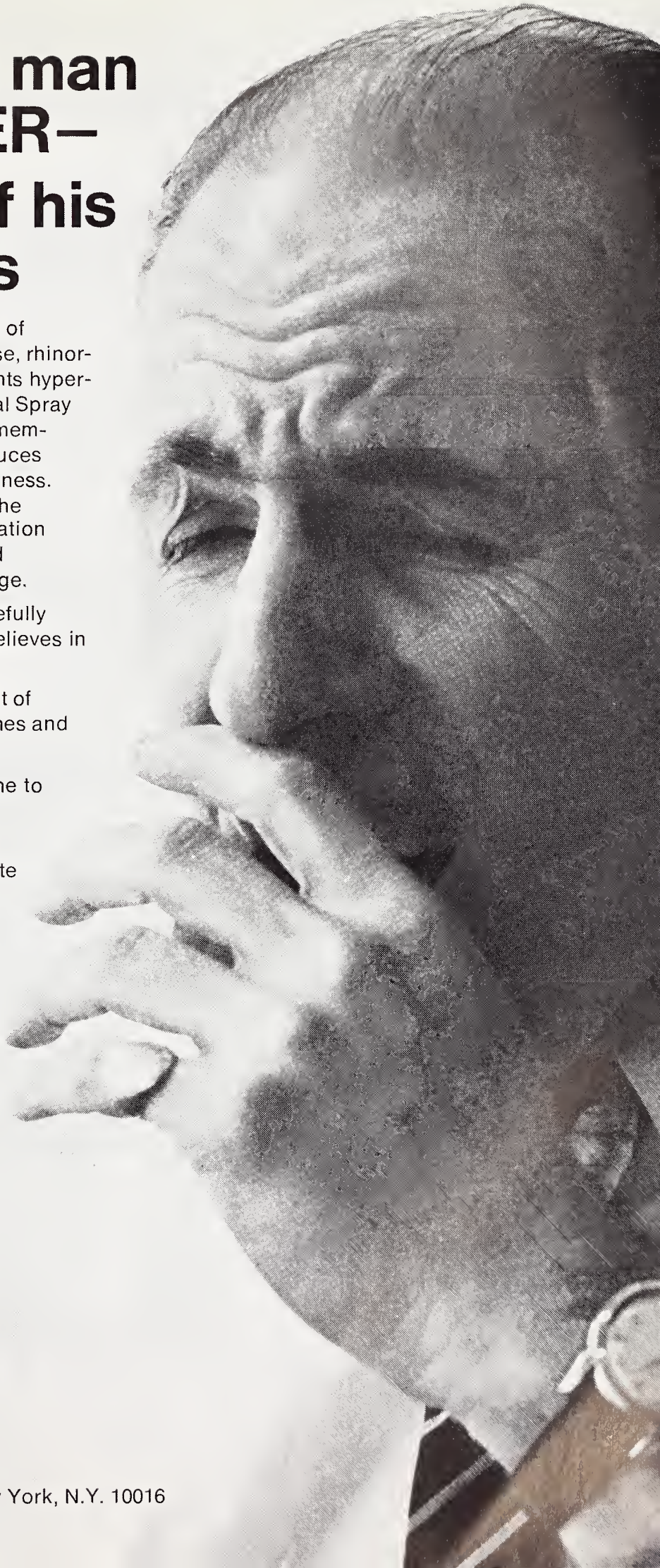

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All amphetamines and barbiturates subject to the law and packaged after September 1 will bear one of the three types of the symbol, prominently placed on the principal panel of the label.

The 13 drugs were added to the control list on May 17. Packagers are allowed up to 180 days after that date for placing the symbol on all new packages.

The newly added drugs are subject to the same record-keeping and prescribing rules as are the non-exempt amphetamine and barbiturate dosage forms.

The following list of drugs by generic names and trade names is quoted from the May 21 issue of *The Newsletter of the American Pharmaceutical Association*, which does not guarantee the list to be either exclusive or complete. Hallucinogenic drugs are listed for sake of completeness, although it is doubtful that any one of them is for sale.

DEPRESSANT DRUGS

Chloral hydrate

trichloroethylidene glycol
chloral
* Beta-chlor (Mead Johnson) chloral betaine, equivalent to 500 mg. chloral hydrate tablets
Felsules (Fellows-Testagar) 250 mg.; 500 mg.; 1 Gm. capsules
Hydral (Person & Covey) 3¼ gr. capsules
Kessodrate (McKesson & Robbins) 250 mg. and 500 mg. capsules
Loranal (Arnar-Stone) 7½ gr. and 15 gr. capsules; also drops
Lycoral (Fellows-Testagar) 10 gr./5 cc liquid
Noctec (Squibb) 7½ gr./5 cc syrup; capsules 250 mg. and 500 mg.
* Periclor (Ives) 5 gr. pentaerythritol chloral capsules
Rectules (Fellows-Testagar) 10 gr. and 20 gr. suppositories
Somnos (MSD) 3¾ gr. and 7½ gr. capsules; 25 gr./fl. oz. elixir

* *Related chemical combinations of chloral hydrate*

Ethchlorvynol

betachlorovinyl ethyl ethynyl carbinol
Placidyl (Abbott) 100 mg.: 200 mg.; and 500 mg. capsules

Ethinimate

1-ethynylcyclohexyl carbamate
Valmid (Lilly) 7½ gr. tablets

Glutethimide

α-phenyl-α-ethyl glutarimide
Doriden (Ciba) 125 mg.; 250 mg.; and 500 mg. tablets; 500 mg. capsules

Methyprylon

3,3-diethyl-5-methyl-2,4-piperidinedione
Noludar (Roche) 50 mg. and 200 mg. tablets; 300 mg. capsules; 50 mg./5 ml. elixir

Paraldehyde

paracetaldehyde
Paral (Fellows-Testagar) 15 gr. capsules; 15 gr./cc ampuls

STIMULANT DRUGS

Methamphetamine

("d" and "dl") and salts

desoxyephedrine
Amphedroxyn (Lilly) 5 mg. tablets
Deofed (Drug Products) 5 mg. capsules
Desamine (Starr) 5 mg. and 10 mg. tablets
Desoxedrine (Testagar) 10 mg. tablets
Desoxo-5 (Sutliff & Case) 5 mg. tablets
Desoxyn (Abbott) 2.5 mg. and 5 mg. tablets; 3.3 mg./5ml. elixir; 5 mg.; 10 mg. and 15 mg. gradumets; 20 mg./cc ampuls
Desyphed (Winthrop) 2.5 mg. tablets
Detrex (Mallard) 10 mg. tablets
Dexoval (Vale) 2.5 mg. and 5 mg. tablets
Dexstim (Central Pharm.) 5 mg. and 10 mg. tablets; 20 mg./ml. vials
D-O-E (Breon) 5 mg. tablets
Doxyfed (Raymer) 2.5 mg. and 5 mg. tablets; 20 mg./fl. oz. elixir
Drinalfa (Squibb) 5 mg. tablets; 20 mg./cc vials
Efroxine (Strasenburgh) 5 mg. tablets
Lanazine (Lannett) 5 mg. and 10 mg. tablets
Methamphin (Rorer) 5 mg. tablets
Methedrine HCl (Burroughs-Wellcome) 5 mg. tablets; 20 mg./cc ampuls
Miller-Drine (Miller) 5 mg. and 10 mg. tablets
Norodin (Endo) 5 mg. tablets
Oxydess (Conal) 8 mg. tablets
Oxydrin (Grant) 2.5 mg. and 5 mg. tablets
Oxyfed (Cole) 5 mg. tablets
Phedoxe (Elder) 5 mg. tablets
Phedrisox (Ascher) 20 mg./cc vials
Premodrin (Premo) 10 mg. tablets
Semoxydrine (Massengill) 5 mg. and 7.5 mg. tablets
Stimdex (Ulmer) 5 mg. tablets
Syndrox (McNeil) 5 mg. tablets; 5 mg./5 cc elixir

Methamphetamine Combinations

Ambar (Robins) with phenobarbital; tablets and Extentab No. 1 and No. 2
Amerital (Merit) with amobarbital, timed capsules
Amphaplex (Palmedico) with amphe-

tamine sulfate and d-amphetamine sulfate tablets
Deltolate (Mallard) with phenobarbital, timed capsulets
Desbutal (Abbott) with pentobarbital, tablets and timed tablets
Doxyfed w/phenobarbital (Raymer) tablets
Obetrol (Obetrol) with amphetamine sulfate and d-amphetamine sulfate, tablets
Phedoxe 4B (Elder) with amobarbital, butabarbital, phenobarbital and pentobarbital, tablets
Phetobese (Cole) with dibasic d-amphetamine phosphate, tablets
Secodrin (Premo) with secobarbital sodium, tablets
Span-RD (Metro Med) with butabarbital, capsules
Syntil (McNeil) with butabarbital sodium, tablets

HALLUCINOGENIC DRUGS

Dimethyltryptamine

DMT
chemically related to psilocyn and psilocybin

d-Lysergic acid diethylamide

obtained from the fungus ergot, *claviceps purpurea*
LSD
LSD-25 (Sandoz) withdrawn from clinical investigation

Mescaline and its salts

obtained from peyote
chemically: 3, 4, 5-trimethoxyphenethylamine

Peyote

Mescal buttons, Peyotl, or *Lophophora Williamsii*
source of mescaline

Psilocybin

hallucinogenic chemical from *Psilocybe mexicana* and related mushrooms
Psilocibin
chemically: 4-phosphoryl-hydroxy-ω-N, N-dimethyl-tryptamine

Psilocyn

hallucinogenic chemical from *Psilocybe mexicana* and related mushrooms
Psilocin ◄

Utilization Review for Nursing Homes

LOWELL H. STEEN, M.D., 10th District Councilor
Whiting

In accordance with the provisions of Public Law 89-97, utilization review procedures similar to those outlined for hospitals have been delineated for extended care facilities (nursing homes). The nursing homes of Indiana have indicated interest in this field and approached the Indiana State Medical Association for guidance in establishing this utilization review procedure. Growing out of this request, the writer, representing the state medical association, spoke to the Indiana State Nursing Home Association meeting in Gary, Indiana on May 12, 1966. The ensuing material is an abstract of those remarks. These comments are set forth in this journal for the information of the county societies in Indiana who may wish to follow similar procedures in setting forth utilization review.

Because there are five separate hospital installations in Lake County, the Lake County Medical Society felt it advisable to be instrumental in setting up the utilization review procedures so as to assure some degree of uniformity. Therefore, each hospital staff was asked to appoint a Utilization Review Committee and the chairman of this committee was automatically made a member of the Lake County Medical Society Utilization Review Committee. A chairman of that group was appointed by the county society. This group has been subsequently charged with the responsibility for utilization review procedures relating to hospitals, home care facilities and nursing homes.

Long Term Care

Although the hospital review is a non-parallel situation with extended care facilities, some mechanism is necessary for appropriate review of the cases in extended care facilities by medical personnel. The very nature of the extended care facility dictates long term stays. The guidelines for deciding upon a period of time at which review should be made would per force need to be extended, and, in many instances, extended to several months; i.e., the case of a fractured hip in an 80-year-old patient. Under this circumstance, at the termination of the first 100 days the patient would, in all probability, have to have additional care, but the care at that point might not be of the type instituted under the Medicare program, although it is urged that standardization of procedures and quality of care be identical for both Medicare participants and non-Medicare participants.

The sections from the instructions of HEW to the nursing homes relative to the clinical records (Section 405.-1132 — Condition of Participation — Clinical Records) is briefly summarized below:

"A clinical record is maintained for each patient admitted, in accordance with accepted professional principles.

Standard; maintenance of clinical record. The extended care facility maintains a separate clinical record for each patient admitted with all entries kept current, dated and signed. The record includes:

(1) Identification and summary sheet(s) including patient's name, Social Security number, marital status, age, sex, home address, and religion; names, addresses and telephone numbers of referral agency (including hospital from which admitted), personal physician, dentist, and next of kin or other responsible person; admitting diagnosis; final diagnosis, condition on discharge and disposition, and any other information needed to meet state

requirements;

(2) Initial medical evaluation including medical history, physical examination, diagnosis and estimation of restoration potential;

(3) Authentication of hospital diagnoses, in the form of a hospital summary discharge sheet, or a report from the physician who attended the patient in the hospital, or a transfer form used under a transfer agreement;

(4) Physician's orders, including all medications, treatments, diet, restorative and special medical procedures required for the safety and well-being of the patient;

(5) Physician's progress notes describing significant changes in the patient's condition, written at the time of each visit;

(6) Nurse's notes containing observations made by the nursing personnel;

(7) Medication and treatment record including all medications, treatments, and special procedures performed for the safety and well-being of the patient;

(8) Laboratory and x-ray reports;

(9) Consultation reports;

(10) Dental reports;

(11) Social service notes;

(12) Patient care referral reports.

Standard; staff responsibility for records. If the extended care facility does not have a full or part-time medical record librarian, an employee of the facility is assigned the responsibility for assuring that records are maintained, completed and preserved. The designated individual is trained by, and receives, regular consultation from a person skilled in record maintenance and preservation."

I feel that these conditions constitute an adequate record upon which to make a review. I have urged the nursing homes to take the initiative in selecting random samplings of their records to be transmitted to a medical society review committee or a committee of their own staff if such exists. The Nursing Home Association was assured that such committees would be set up in most counties in Indiana, and they were further assured that the Indiana State Medical Association would do whatever possible to aid in the establishment of these committees. It is recognized that there are areas in the state where physicians do not wish to participate in this program, but I think that with time, it will become a necessity and there will be virtually uniform participation.

Duplication of Records

It was suggested that in order to have adequate clinical records at the nursing homes, the affiliated hospitals set up a mechanism by which the history and physical examination can be photo-reproduced along with the last three days' progress notes and the discharge summary. It was further urged that physicians be encouraged to write dismissal orders on the order sheet and that this likewise be photo-reproduced and dispatched with the patient to the extended care facility. This will obviate much paper work on the part of the physician since this has been done on admission to the hospital.

I might point out here, although I did not say this to the Nursing Home Association, that in my opinion, the hospital staffs will have to implement and monitor the time of completion of histories and physicals since in many hospitals the stenographic pool is as much as seven to ten days behind in the transcription of hospital records. I suggest that where possible, on transfer, these histories and physicals be given priority in the stenographic pool so as to be available at the time of transfer, otherwise the efficiency of the entire system will be lost.

Based upon Section 405.1137 of Public Law 89-97 (Condition of Participation-Utilization Review Plan) the type of review that must be conducted must be concerned with the diagnosis for which the patient was admitted, what services rendered in the nursing home, i.e., physical therapy, special dietary management, drugs and medications, intravenous infusions and general nursing care. These elements should be studied from the standpoint of whether or not they were ordered and the appropriateness of the order, as well as a regard for those modalities which were available and were not used. This section is an almost verbatim recounting of the utilization review procedure for short term facilities (general hospital).

As to the possibility of decreasing the length of stay in extended care facilities, I believe that this is virtually impossible to make any prediction about. I think to a large extent it will depend upon the home nursing services available in the community and, parenthetically, where possible, they should be utilized to the fullest to conserve acute facility beds.

The immediate transfer from the hospital to a nursing home was discussed. Some mechanism by which patients who need only nursing home care but who must be hospitalized for three days in the acute facility to qualify for nursing home benefits requires further attention. It is my understanding that Senator Bayh of Indiana has introduced a bill to Congress to amend PL 89-97 in such a way that direct admission to nursing home facilities can be made. I believe this would be a salutary amendment to the bill! I can foresee some resistance to this on the part of many physicians, but I can also foresee the unnecessary utilization of hospital beds to satisfy this requirement because of language of the law.

A "Dumping Ground"

I urge the county medical societies throughout the state to get adequate utilization committees set up. I think the matter of utilization review in extended care facilities is a bit facetious, since if someone needs prolonged detention in a nursing home, he should have prolonged care. On the other hand, I vehemently feel that extended care facilities should not become a dumping ground for elderly people whose families no longer wish to care for them. Yet, in essence, that is the major population of many nursing homes today!

It is urged that parameters of resi-

dence be set up for various disease entities since it is obvious that a patient discharged from a hospital after a cholecystectomy might need only a short stay in a nursing home before he is able to take care of himself, whereas the case of the fractured hip might require seven, eight or twelve months of care prior to being self-sufficient.

There is no great probability of controversy between the Utilization Review Committee and the attending physician. It is suggested that the Utilization Review Committee, in all probability, would not insist on discharge in contravention of the attending physician's judgment to continue hospitalization because of the legal implication.

It is recognized that throughout the state the manner in which nursing homes are run varies with the size of the community and the proximity of the physician. In those areas where physicians regularly call at nursing homes, the same procedure for progress notes and written orders should be followed as is followed in the acute care facility. In areas where there are large numbers of nursing homes in diverse locations distant from the locus of practice of the physician, calls are rarely made at the nursing home facility. Under these circumstances, it is incumbent upon the nursing home to have a medical director or attending physician who regularly calls who would then become responsible to care not only for the medical needs of the patients, but also of the paperwork (with the consent of the attending physician). Most physicians today do not have time to visit five or six nursing homes each week to visit patients who are residents there. Local option is per force a necessity!

It is obvious from reading Public Law 89-97, The AMA Advisory Report and Guidelines to Extended Care Facilities and the publications of HEW, that those parties responsible for writing the regulations and the bill had little conception of what a nursing home is or how it operates. Again, it becomes our obligation to aid in unsnarling the intricacies of ill-conceived and badly planned regulations. There is no question that participation in utilization review is onerous, time-consuming and in no measure soul satisfying, yet the alternatives clearly forebode controversy, entanglement, time-consuming correspondence and additional paperwork. ◄

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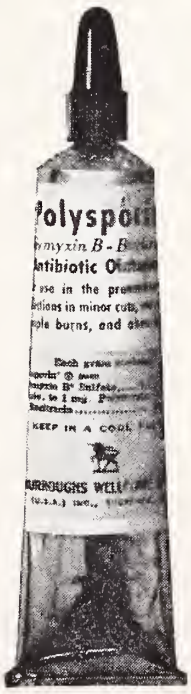
in treating topical infections, no need to sensitize the patient



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Medicine At Law

DECISIONS AND OPINIONS

Highlights of recent court actions pertaining to health and medicine from *The Citation* prepared by the Law Division of AMA.

No Absolute Right to Have Attorney Present at Physical Examination — In a woman's suit for damages for personal injuries, a trial court did not err in ordering her to submit to a physical examination, outside of the presence of her attorney, by a physician chosen by the person against whom the suit was brought, a Louisiana intermediate appellate court ruled.

The woman contended that she had an absolute right to have her attorney present at the physical examination. The discovery statute does not provide for the presence of counsel at examinations. It provides that the trial court shall specify the "conditions" of the examination. Whether counsel should be present is one of the "conditions" to be determined by the trial court in the exercise of its discretion. The examinee does not have an absolute right to have an attorney present. The examination is not an adversary proceeding. The presence of an attorney would probably tend to prolong the examination.

Although there is no absolute right to have an attorney present, a court may permit it on a showing of special circumstances requiring it. The woman's attorney filed an affidavit stating that in other cases in which his clients had been examined by physicians selected by the opposing party, the physicians had asked improper questions and this had given rise to issues of veracity between the examinees and the physicians at the trial. It could not be presumed, as the attorney did in his affidavit, that all physicians retained to examine an injured party by the person against whom suit is brought will act improperly, the court said. If the trial court, in its discretion, decides that a particular physician may act improperly, it may refuse the request for the examination, designate another physician, specify the scope of the examination, or require that the examinee's attorney be present. Whether or not a member of the examinee's family or some other person should be permitted to be present is also a matter within the trial court's discretion.

The woman appeared at the physician's office as ordered. She gave him a written medical history, prepared by her attorney, and said she would not answer any questions about the history. This did not constitute compliance with the trial court's order. A physician cannot form a professional opinion unless he personally elicits what he considers to be the relevant facts, the court said.

Simon v. Castille, 174 So.2d 660 (La., April 19, 1965; rehearing denied, May 19, 1965).

Jehovah's Witnesses Sue in Federal Court in State of Washington to Restrain Forced Transfusions — A suit for a declaration of legal rights of members of the Jehovah's Witnesses religious faith in relation to blood transfusions and for restraint against interference with such rights by physicians, hospitals, judges, governmental officials, and others has been filed in the federal trial court in Seattle, Washington. Suit was filed by a number of members of this faith individually and as representatives of others similarly situated, and by the Watchtower Bible and Tract Society of Pennsylvania, against a number of hospitals, hospital officials, governmental officials, judges and physicians. The hospitals and the physicians are sued individually and as representatives of others similarly situated.

The complaint claims that the religious freedom of members of the faith has been interfered with by the practice of obtaining court orders removing children from the custody of parents so that blood transfusions may be given to them and by the refusal of medical treatment to adult members of the faith unless they agree to consent to transfusions. It also claims that there is a conspiracy among the named defendants and others to accomplish these results. It claims that the medical benefits of administering blood transfusions have not been established and that this form of treatment is being forced on members of the faith in disregard of its known hazards.

Jehovah's Witnesses in the State of Washington v. King County Hospital Unit No. 1, No. 6595, U.S. Dist. Ct., W. Dist., N. Div., Nov. 12, 1965.

Citation Editor's Note: On the basis of Biblical texts which condemn the "eating of blood," the doctrine of the Jehovah's Witnesses faith holds that it is contrary to the law of God and highly immoral for any member of the faith to receive a transfusion. With a few exceptions, the courts have held that a transfusion cannot be forced on an adult without consent. Because of the well-established interest of

Continued

Behind continued high blood pressure readings lies the possibility of organic damage[1-13]

MANY OF THE aspects of essential hypertension are unpredictable—either because there are a number of mechanisms involved or because individuals differ in their responses to these mechanisms.[1]

There is one aspect of hypertension, however, that seems, in many cases, predictable. ". . . when the blood pressure is elevated to a marked degree for an adequate period of time, this in itself leads to perpetuation of the syndrome with resulting vascular damage throughout the body."[14] All too often the disease progresses until there is damage to one of three vital organs: the heart, the kidney, the brain.

"Hypertension is certainly a major factor in the genesis of coronary heart disease, and it is even more important when compounded with obesity."[4]

"[Vascular deterioration] can be clearly seen in the kidney with a degree of damage that can be measured by renal function studies."[10]

". . . most evidence suggests that reduction of blood pressure, when it is too high, not only relieves the heart of excess work but reduces vascular damage."[1]

"In short, treatment is indicated."[1]

Antihypertensive therapy will not restore the blood vessels to normal. Yet many of the vascular changes and symptoms caused by increased blood pressure may be arrested or alleviated when the blood pressure is reduced to normotensive levels.[7]

Reducing the blood pressure helps curtail further vascular damage and improves the prognosis — when damage is not too far advanced before therapy is started.[14] Essential hypertension is an indication not only for treatment, but for *early* and adequate treatment of the patient in question.

Reduce the blood pressure with Rautrax-N

Rautrax-N combines the antihypertensive-tranquilizing action of whole root rauwolfia with the antihypertensive-diuretic action of bendroflumethiazide in one convenient medication. The two drugs complement each other so that smaller doses of both are possible.

Rauwolfia combined with bendroflumethiazide is particularly effective in long-term therapy,[15-17] since beneficial effects do not diminish with continuous daily administration.

For most patients 1 or 2 Rautrax-N tablets daily are sufficient for maintenance therapy. The simplicity, convenience and economy of such a dosage schedule are of particular benefit to older patients.

References: **1.** Page, I. H., and Dustan, H. P.: The Usefulness of Drugs in the Treatment of Hypertension, in Ingelfinger, F. J.; Relman, A. S., and Finland, M.: Controversy in Internal Medicine, Philadelphia, W. B. Saunders Co., 1966, p. 95. **2.** Hollander, W.: The Evaluation of Antihypertensive Therapy of Essential Hypertension in Ingelfinger, F. J.; Relman, A. S., and Finland, M.: Controversy in Internal Medicine, Philadelphia, W. B. Saunders Co., 1966, p. 97. **3.** Nickerson, M.: Antihypertensive Agents and the Drug Therapy of Hypertension, in Goodman, L. S., and Gilman, A.: The Pharmacological Basis of Therapeutics, ed. 3, New York, The Macmillan Co., 1965, p. 727. **4.** Berkson, D. M.: Indust. Med. & Surg. **32**:371, 1963. **5.** Cohen, B. M.: M. Times **91**:645, 1963. **6.** Lee, R. E., et al.: Am. J. Cardiol. **11**:738, 1963. **7.** Moyer, J. H.: Am. J. Cardiol. **9**:821, 1962. **8.** Moser, M.: New York J. Med. **62**:1177, 1962. **9.** Wood, J. E., and Battey, L. L.: Am. J. Cardiol. **9**:675, 1962. **10.** Moyer, J. H., and Heider, C.: Am. J. Cardiol. **9**:920, 1962. **11.** Moser, M., and Macaulay, A. I.: New York State J. Med. **60**:2679, 1960. **12.** Judson, W. E.: Nebraska M. J. **44**:305, 1959. **13.** Hodge, J. V.; McQueen, E. G., and Smirk, H.: Brit. M. J. **1**:5218, 1961. **14.** Moyer, J. H., and Brest, A. N.: Hypertension Recent Advances, Philadelphia, Lea & Febiger, 1961, p. 633. **15.** Berry, R. L., and Bray, H. P.: J. Am. Geriatrics Soc. **10**:516, 1962. **16.** Reid, W. J.: J. Am. Geriatrics Soc. **13**:365, 1965. **17.** Feldman, L. H.: North Carolina M. J. **23**:248, 1962.

Contraindications: Severe renal impairment or previous hypersensitivity. **Warning:** Ulcerative small bowel lesions have occurred with potassium-containing thiazide preparations or with enteric-coated potassium salts supplementally. Stop medication if abdominal pain, distension, nausea, vomiting or G.I. bleeding occur.

Precautions and Side Effects: The dose of ganglionic blocking agents, veratrum or hydralazine when used concomitantly must be reduced by at least 50% to avoid orthostatic hypotension. Caution is indicated in patients with depression, suicidal tendencies, peptic ulcer; electrolyte disturbances are possible in cirrhotic or digitalized patients. Marked hypotension during surgery is possible; consider discontinuing two weeks prior to elective surgery and observe patients closely during emergency surgery. Rauwolfia preparations may cause reversible extrapyramidal symptoms and emotional depression, diarrhea, weight gain, edema, drowsiness may occur. Bendroflumethiazide may cause increases in serum uric acid, unmask diabetes, increase glycemia and glycosuria in diabetic patients, and may cause hypochloremic alkalosis, hypokalemia; cramps, pruritus, paresthesias, rashes may occur.

Dosage and Supply: Initial dosage, 1 to 4 tablets daily, preferably at mealtime. Maintenance, 1 or 2 tablets daily. Rautrax-N is supplied as capsule-shaped tablets containing 50 mg. Rauwolfia serpentina whole root (Raudixin®), 4 mg. bendroflumethiazide (Naturetin®), 400 mg. potassium chloride.

Also available: Rautrax-N Modified — capsule-shaped tablets containing 50 mg. Rauwolfia serpentina whole root (Raudixin), 2 mg. bendroflumethiazide (Naturetin), 400 mg. potassium chloride. Both potencies available in bottles of 100. For full information, see Product Brief.

RAUTRAX®-N

Squibb Rauwolfia Serpentina Whole Root (50 mg.) with Bendroflumethiazide (4 mg.) and Potassium Chloride (400 mg.)

Continued

the state in the welfare of children, however, most courts will take action to authorize transfusions for children, if such therapy is determined to be medically necessary. It is also well-established law that a physician cannot give any patient any treatment without consent and that a physician may refuse to undertake treatment of a patient if the patient refuses to accept his advice.

Hospital Denied Order Requiring Trial Court's Dismissal of Osteopath's Suit For Denial of Staff Privileges — A hospital was not entitled to an order directing a trial court to set aside its denial of the hospital's motion to dismiss a suit by an osteopath to enjoin the hospital from excluding him from the use of its facilities, the Indiana Supreme Court ruled.

It was the hospital's position that, since a trial court's injunctive power is limited to the protection of civil and property rights, and there is no civil or property right to practice medicine in a particular hospital, the trial court did not have jurisdiction in the osteopath's suit against it.

The hospital's application for the order was not timely. It had submitted to the trial court's jurisdiction for more than a year and a half, and did not apply for the order until it had exhausted all possibilities short of going to trial. A determination of the osteopath's right to an injunction depends on the interpretation of a statute and several cases.

Whether he has such a right is a matter as to which there is room for reasonable difference of opinion. Since no temporary injunction had been asked for or issued, there was no emergency. The most that can happen to the hospital is that the osteopath's suit will be heard on its merits.

State ex rel. Gibson General Hospital v. Warrick Circuit Court, 214 N.E. 2d, 655 (Ind., March 9, 1966). ◄

Stronger Blue Shield Program For General Motors

(One of a series prepared by Blue Cross-Blue Shield)

Effective September 1, 1966, changes in the Blue Cross-Blue Shield program for approximately 40,000 General Motors employees in Indiana will provide some 140,000 members and dependents much broader protection than they now have. This continues a trend that has been maintained through the years by this account.

The most significant changes in the Blue Cross program are the addition of outpatient psychiatric care, and convalescent and long-term illness care. Both benefits tie in with new Blue Shield programs.

The new Blue Shield benefit for outpatient psychiatric care includes payment on a deductible basis for psychotherapeutic services in an approved hospital, day or night care center, or a community mental health care center, including individual or group psychotherapeutic services in a physician's office or approved facility. The maximum payment for combined Blue Cross-Blue Shield services will be limited to $400.00 per year.

The new Blue Shield benefit for "medical care in a convalescent or long-term illness institution" provides payment for the attending physician's visit, not to exceed one visit per day. Total visits will be limited to 365 days during a 730-day period. For any care received in a general hospital, one day's treatment will be computed as two days' visits.

Payments by Blue Shield for surgical services, in-hospital medical care, anesthesia and radiation therapy effective September 1, will be made according to the county program where available or the usual and customary charges for the area in which such services are rendered, where county programs are not available.

A female employee or female dependent shall be entitled to obstetrical benefits, under the following condition:

The maximum Blue Shield benefit will be allowed when a minimum of eight prenatal and one postpartum visits were made to the physician's office and the actual delivery was made by the physician, or at least under his responsibility.

Under in-hospital medical care, the maximum number of days provided for the treatment of a nervous or mental condition has been increased to 45. The indemnities provided for the treatment of nervous and mental conditions have been increased to a limit of $15.00 for the first day, $10.00 for the second day and $5.00 for each succeeding day.

Unmarried dependent children are covered until the end of the calendar year in which the age of 25 is attained, or indefinitely, as long as they are totally and permanently disabled by reason of physical or mental conditions.

With the guidance of Indiana doctors, Blue Shield will continue to keep up with the changing conditions of medical practice, developing and selling benefit programs that meet the real needs of the people of Indiana. ◄

W. C. Huddlestone
Communications Division

The human spine is not engineered for prolonged sitting at desks, pianos, typewriters and drafting boards. The stresses set up by the heavy, forward-tilted head and trunk, balanced precariously on an insufficient base, result in strain of the dorsal musculature, particularly at the low lumbar level.

The unusual muscle-relaxant and analgesic properties of 'Soma' make it especially useful in the treatment of low back sprains and strains. 'Soma' is widely prescribed ☐ **to relieve pain** ☐ **to relax muscles** ☐ **to restore mobility.**

Indications: 'Soma' is useful for management of muscle spasm, pain, and stiffness in a variety of inflammatory, traumatic, and degenerative musculoskeletal conditions. It also may act to normalize motor activity in certain neurologic disturbances.

Contraindications: Allergic or idiosyncratic reactions to carisoprodol.

Precautions: 'Soma', like other central nervous system depressants, should be used with caution in patients with known propensity for taking excessive quantities of drugs and in patients with known sensitivity to compounds of similar chemical structure, e.g., meprobamate.

Side Effects: The only side effect reported with any frequency is sleepiness, usually on higher than recommended doses. An occasional patient may not tolerate carisoprodol because of an individual reaction, such as a sensation of weakness. Other rarely observed reactions have included dizziness, ataxia, tremor, agitation, irritability, headache, increase in eosinophil count, flushing of face, and gastrointestinal symptoms.

One instance each of pancytopenia and leukopenia, occurring when carisoprodol was administered with other drugs, has been reported, as has an instance of fixed drug eruption with carisoprodol and subsequent cross reaction to meprobamate. Rare allergic reactions, usually mild, have included one case each of anaphylactoid reaction with mild shock and angioneurotic edema with respiratory difficulty, both reversed with appropriate therapy. In cases of allergic or hypersensitivity reactions, carisoprodol should be discontinued and appropriate therapy initiated. Suicidal attempts may produce coma and/or mild shock and respiratory depression.

Dosage: Usual adult dose is one 350 mg. tablet three times daily and at bedtime.

Supplied: Two Strengths: 350 mg. white tablets and 250 mg. orange, two-piece capsules.

Before prescribing, consult package circular.

for the relief of low back sprains and strains

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(CARISOPRODOL)

Wallace Laboratories, Cranbury, N.J.
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AESCULAPIUS AWARD WILL GO TO OUTSTANDING ISMA SCIENTIFIC EXHIBIT

The Indiana State Medical Association, in cooperation with Mead Johnson Laboratories, takes pleasure in announcing the AESCULAPIUS AWARD, to be presented to the author of the most outstanding scientific exhibit shown at the 1966 annual session.

The scientific exhibits will be judged by a committee of the medical association, and the winner of the Aesculapius Award chosen by them. The winner will be presented with a certificate, suitably inscribed with the title of the exhibit and the author's name, and will receive a $200.00 cash prize donated by Mead Johnson Laboratories. Presentation will be made during the convention.

All exhibits accepted for showing at the 1966 annual session of the Indiana State Medical Association will be eligible for judging in this contest. Physicians interested in submitting exhibits for showing at the annual meeting should make application to the Indiana State Medical Association, 3935 N. Meridian St., Indianapolis 46208.

The concept underlying the Aesculapius Award program involves a twofold purpose—to enhance the quality of scientific exhibits presented at the annual meeting and thus the educational value to the members attending, and to stimulate increased participation on the part of ISMA members.

INDIANA MEDICAL AUXILIARY RECEIVES TWO AMA FOUNDATION AWARDS

The Woman's Auxiliary to the Indiana State Medical Association received an award of merit for its outstanding effort in the American Medical Association Education and Research Foundation program in 1965-66. The presentation was made during the 43rd Annual Convention of the Woman's Auxiliary to the AMA in June.

The Indiana Auxiliary made the greatest contribution of any state group in the 2,001-to-3,000 member category — $17,650.80.

The Woman's Auxiliary to the Vanderburgh-Southwestern, Indiana, Medical Society also received a special achievement award for its outstanding efforts in the program.

With a membership of 189, the Vanderburgh-Southwestern Auxiliary raised $3,219.96 for AMA-ERF. Total national contribution was $345,573.81, part of which will be given to medical schools for unrestricted use. The remainder will go to the student loan guarantee fund. This fund makes possible long-term bank loans to medical students, interns and residents, with no payment due on either interest or principal until five months after completion of all training. AMA-ERF acts as guarantor. For each $100 contributed, $1,250 in loans is made available.

Medicare Check List Published for Guidance and Information of Patients

The American Society of Internal Medicine has published a check list for the guidance and information of patients eligible for Medicare benefits. The small folder outlines benefits which are covered and those which are not.

Although designed for use by internists, it is suitable for use by all physicians for distribution to patients. Copies may be obtained at the rate of $3.90 per 100, $16.50 per 500 and $32.50 per 1,000, postpaid. The Society address is 3410 Geary Blvd., San Francisco 94118.

Highway Safety Booklet Available to Physicians

"You Bet Your Life" is the title of the 1966 edition of the Travelers Insurance Companies booklet on highway safety. Pertinent data on street and highway auto accidents are presented in dramatic style and with clever cartoon illustrations designed to promote safe driving.

The booklet may be obtained singly or in quantities, as long as the supply lasts, from a Travelers representative or by writing the company at Hartford, Connecticut 06115.

"Finding the Hidden Diabetic" Film Available for Meetings

Early diagnosis of diabetes is discussed in a new 39-minute movie film made by the Upjohn Company for showing at hospitals and medical meetings. "Finding the Hidden Diabetic" is the title. The importance of early discovery, the method of early discovery and methods of lessening the vascular complications are discussed.

Dr. Alexander Marble, Dr. Glen W. McDonald, Dr. Gerald T. Kent and Dr. Samuel Andelman present the discussion by the panel method. Upjohn will also furnish, either with the film or separately, a 14-page brochure on the same subject. Requests for film and/or brochure should be addressed to Diabetes Detection Program, Room 914, 342 Madison Ave., New York City 10017.

Wyeth Fellowship Presented To Gary, Indiana Physician

The Wyeth Fund for Postgraduate Medical Education has awarded one of its 15 two-year Fellowships in pediatrics this year to Dr. Paul V. Baranko, Gary, Indiana, who will study at Indiana University Medical Center, Indianapolis.

This is the ninth group of pediatric residents to receive the Wyeth Fellowships. Each award is for $4,800 and is given to help meet the expenses of advanced study.

Tri-State Hospital Assembly Elects Edgar C. Kruse to Post

The Tri-State Hospital Assembly which represents the hospitals of Indiana, Illinois, Michigan and Wisconsin, elected Edgar C. Kruse, administrator of the Lutheran Hospital of Fort Wayne, as president-elect during its annual meeting in Chicago recently. Mr. Kruse has been with the Lutheran Hospital since 1952 and has been its administrator since 1959. He has had several positions in the Tri-State Assembly, as well as in national and Indiana hospital organizations.

One of the four Awards of Merit of the Tri-State Hospital Assembly was given to Everett A. Johnson, Ph.D., administrator of the Methodist Hospital of Gary, in honor of his contributions to progress

REPRESENTATIVES of the Indiana State Medical Association took part in the inauguration of the first TWA DC-9 Jet Flight to Washington, D.C., April 24. Occasion was the annual reception for and visitation of Indiana's congressmen sponsored by the ISMA. Making the flight were (left to right) Dr. and Mrs. James M. Kirtley, Crawfordsville; Dr. and Mrs. Otis R. Bowen, Bremen; James A. Waggener, Executive Secretary, ISMA; Ralph V. Everly, M.D., Indianapolis, chairman of the Executive Committee; Dwight W. Schuster, M.D., chairman of the state association's Legislative Commission and Field Secretaries Howard Grindstaff and Robert Amick. On the steps (top to bottom) ore Eugene S. Rifner, M.D., Van Buren, President-Elect; G. O. Larson, LaPorte, Executive Committee member; and Kenneth O. Neumann, M.D., Lafayette, President of ISMA. Doctars Kirtley and Bowen also serve on ISMA's Legislative Commission.

of hospital care and to the development of the educational purposes of the Assembly.

Eli Lilly & Company Exhibit At Weir Cook Draws Crowds

Eli Lilly and Company maintains an exhibit at the Weir Cook Airport, Indianapolis, to acquaint the public with the importance of pharmaceutical research and production to the nation's health.

An eight-minute color movie with sound track per telephones is the heart of the exhibit. At the exhibit's present rate of stop, look and listen, more than 60,000 persons will view and hear the message this year.

Brochure Available to Encourage Young People to Enter Medicine

"The Opportunities and Rewards of Medicine Can Be Yours" is the title of a brochure developed by the AMA as an aid for use in programs designed to encourage young people to consider carecrs in medicine.

Copies are available for career counsellors by writing the Program Services Department, AMA, 535 N. Dearborn St., Chicago 60610.

New York Life Announces New Medical Scholarships

The New York Life Insurance Company announces the establishment of a medical student scholarship program in cooperation with eleven participating medieal schools, one of which is Indiana University School of Medicine.

Indiana and ten other schools of United States and Canada will receive each year, beginning this fall, a scholarship grant to be awarded to a first-year student of the school's choice. The grant will cover tuition, room, board, fees, books and equipment, and will be known as the New York Life Medical Scholarship.

Dr. Wray Appointed Chairman of the Department of Orthopaedic Surgery at I.U.

Dr. James B. Wray, head of orthopaedic surgery at the State University of New York, Syracuse, has been appointed chairman of the Department of Orthopaedic Surgery at the Indiana University School of Medicine.

As chairman, Dr. Wray succeeds Dr. George J. Garceau, well-known orthopaedic surgeon who also holds the title orthopaedist to the James Whitcomb Riley Hospital for Children, one of the University hospitals. Dr. Garceau, who has been on the I.U. faculty since 1928 and chairman of the department since 1947, will continue to teach. Many of the orthopaedic surgeons in the middle west and throughout the country have had their training under him, and at a recent dinner-meeting here, he was honored by his former residents through the establishment of an annual Garceau Memorial Orthopaedic Lecture and a Garceau Memorial Research Fund.

In New York, Dr. Wray also has been chief of service of the Syracuse Memorial Hospital, University Hospital, and Utica Children's Hospital Home, and a staff member of the Veterans' Administration Hospital and Crouse-Irving Hospital.

A native of Tennessee, he received the B.S. degree in 1948 and the M.D. degree in 1950 from the University of Tennessee, and did graduate studies at New York University, Northwestern University, and Oak Ridge Nuclear Institute. Dr. Wray served his internship at the University of Michigan in 1950-51, and held a National Foundation Infantile Paralysis Fellowship in orthopaedic surgery at Duke University from 1953 to 1957. He taught at Duke and in the Bowman Gray School of Medicine.

Dr. Wray has served as an examiner for the American Board of Orthopaedic Surgery, and as secretary and chairman of the Section of Orthopaedic Surgery of the New York State Medical Society.

The holder of a number of research grants, he has received the following awards:

Kappa Delta Award for Research in Orthopaedic Surgery, "Vascu-

lar Phenomena Associated with Fracture"; Angiology Research Foundation, "Vascular Regeneration in the Healing Fracture," and Nicholas Andry Award for Research in Orthopaedic Surgery, "The Influence of Various Hormones Upon the Fracture Healing Process." He has served as a visiting lecturer at the Universities of Kansas, Michigan and Pennsylvania, and is the author or co-author of 35 articles for professional journals.

In addition to his teaching and administrative responsibilities at the I.U. School of Medicine, Dr. Garceau has been sought after as a speaker at many state and county medical association meetings, and has been a visiting professor at several medical schools. Author of at least 25 published articles, he has presented many unpublished papers before various orthopaedic groups, the last one being given before the Academy in January. He has been an examiner for the American Board of Orthopaedic Surgery, Inc., for 25 years, is a past-president of the board and a past chairman of the Examination Committee.

Dr. Garceau has served as president of the Clinical Orthopaedic Society and vice-president of the American Academy. He has been active in all the national and international societies related to his fields.

Three Inducted as Fellows

Drs. Peter P. Mayock, Jr., of Bluffton, John H. Ivy, Elkhart and Joseph Ross, Indianapolis were inducted as Fellows of the American College of Physicians at the recent Annual Session of the College at New York City.

New, Revised Edition of "The Fat And Sodium Control Cookbook" Available

"Low Sodium, Fat-Controlled Cookbook" by Payne and Callahan has been revised under a new title "The Fat and Sodium Control Cookbook."

The new revision has been published by Sunkist Growers and is available from them for $3.00. The address is Sunkist Growers, Section 30CS, Box 2706, Terminal Annex, Los Angeles, California 90054.

New Viet Nam Field Director

Dr. Malcolm E. Phelps, El Reno, Oklahoma, will serve in the new post of field director of Project Viet Nam, a joint program of the U. S. State Department and the AMA to provide volunteer U. S. doctors to care for Vietnamese civilians.

Dr. Phelps is in Viet Nam now and will probably work there for at least six months. There is one doctor per 23,000 people in Viet Nam. American volunteers are spending a few months each in Viet Nam to improve the civilian medical service.

Army Commissioning Women Physicians Now for Service

The Army is commissioning women physicians now for service either in continental U. S. or overseas, as desired. Women physicians will not be involuntarily assigned to overseas areas during the initial tour of duty.

It has been found that women physicians are able to perform all duties equally as well as men in the various medical specialties. Twenty-three were on duty with the Army during the Korean War. Those interested should apply to The Surgeon General, Attn: MEDPT-MP, Department of the Army, Washington, D. C. 20315.

Copies of "Medical Evaluation of the Commercial Vehicle Driver" now Available

"Medical Evaluation of the Commercial Vehicle Driver" is the title of a report published by the Industrial Medical Association to aid the physician in examining drivers and prospective drivers for commercial vehicles.

The report discusses physical, emotional and mental standards. Copies may be obtained at 30 cents per from the Association at 55 E. Washington, Chicago 60602.

Lilly Film Wins 1966 Golden Eagle Award

"Fertility Control: The Role of the Oral Contraceptives" a medical educational film produced by Eli Lilly & Company to explain the type of ovulation control achieved by C-Quens, has been selected by the Council on International Nontheatrical Events for a 1966 Golden Eagle Award.

The film has also received a bronze award at the Fifth International Film and Television Festival. Three hundred and fifty copies of the film have been required to meet the demand for showings. It is distributed by Lilly's audiovisual film library.

Hoosier Doctors to Participate in Flying Physicians Association Program

Hoosier physicians will participate in the program of the Flying Physicians Association during its annual meeting in Las Vegas, September 11 to 16. Dr. Neal E. Baxter, Bloomington, will moderate a roundtable discussion on the management of diabetes.

Dr. Merritt O. Alcorn, Jr., of Madison, will moderate a clinico-pathologic conference and Dr. Gerald F. Ward, Fort Wayne, will moderate a roundtable discussion on "Urinary Tract Infection and Other Urologic Problems." The Association has a membership of over 1,800, 117 of whom are Hoosiers. ◄

VISITORS in Indianapolis for the 500 Mile Race classic at the Indianapolis Motor Speedway were (center) L. O. Simenstad, M.D., Osceola, Wisconsin, member of the American Medical Association's Board of Trustees and (right) Donovan F. Ward, M.D., Dubuque, Iowa, immediate past-president, AMA. Dr. Lester D. Bibler, (left) Indianapolis, also a member of the AMA Board of Trustees, chats with them. He and Mrs. Bibler were hosts to the two physicians and their wives.

Forty-eight thousand, five hundred persons were killed in 1965 on the nation's highways, according to a report by The Travelers Insurance Companies. In addition, 4,100,000 others were injured in traffic accidents last year.

* * * *

Drivers under 25 years of age represent only about 18% of all licensed drivers in the U.S., but in 1965 they were involved in more than 30% of all fatal traffic accidents and 28% of all non-fatal highway mishaps.

Diagnosis:

cystitis?
pyelonephritis?
pyelitis?
urethritis?
prostatitis?

in any case,
usually gram-negative*

Therapy:

two 500 mg. Caplets® q.i.d.
(initial adult dose)

Indications: Urinary tract infections caused by gram-negative and some gram-positive organisms.

Side effects: Mainly mild, transient gastrointestinal disturbances; in occasional instances, drowsiness, fatigue, pruritus, rash, urticaria, mild eosinophilia, reversible subjective visual disturbances (overbrightness of lights, change in visual color perception, difficulty in focusing, decrease in visual acuity and double vision), and reversible photosensitivity reactions. Marked overdosage, coupled with certain predisposing factors, has produced brief convulsions in a few patients.

Precautions: As with all new drugs, blood and liver function tests are advisable during prolonged treatment. **Pending further experience, like most chemotherapeutic agents, this drug should not be given in the first trimester of pregnancy. It must be used cautiously in patients with liver disease or severe impairment of kidney function.** Because photosensitivity reactions have occurred in a small number of cases, patients should be cautioned to avoid unnecessary exposure to direct sunlight while receiving NegGram, and if a reaction occurs, therapy should be discontinued. The dosage recommended for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Bacterial resistance may develop.

When testing the urine for glucose in patients receiving NegGram, Clinistix® Reagent Strips or Tes-Tape® should be used since other reagents give a false-positive reaction.

Dosage: Adults: Four Gm. daily by mouth (2 Caplets® of 500 mg. four times daily) for one to two weeks. Thereafter, if prolonged treatment is indicated, the dosage may be reduced to two Gm. daily. Children may be given approximately *25 mg. per pound* of body weight per day, administered in divided doses. The dosage recommended above for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Until further experience is gained, infants under 1 month should not be treated with the drug.

How supplied: Buff-colored, scored Caplets® of **500 mg. for adults,** conveniently available in bottles of 56 (sufficient for one full week of therapy) and in bottles of 1000. **250 mg. for children,** available in bottles of 56 and 1000.

References: (1) Based on 23 clinical papers, 1512 cases. Bibliography on request. (2) Bush, I. M., Orkin, L. A., and Winter, J. W., in Sylvester, J. C.: Antimicrobial Agents and Chemotherapy—1964, Ann Arbor, American Society for Microbiology, 1965, p. 722.

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eradicates most urinary tract infections...

- Low incidence of untoward effects; no fungal overgrowth, crystalluria, ototoxic or nephrotoxic effects have been observed.
- "Excellent" or "good" response reported *in more than 2 out of 3* patients with either chronic or acute gram-negative infections.[1]

*As many as 9 out of 10 urinary tract infections are now caused by gram-negative organisms: E. coli, Klebsiella, Aerobacter, Proteus, Paracolon or Pseudomonas[2]... However, infections of the urethra and prostate caused by non-gonococcal gram-negative organisms are believed to be less prevalent.

Annual Otolaryngologic Assembly Will be October 1-7 at Chicago

The Annual Otolaryngologic Assembly of 1966 will be held October 1 through 7 in the new Illinois Eye and Ear Infirmary at the Medical Center, Chicago.

The Department of Otolaryngology of the College of Medicine of the University of Illinois offers a condensed postgraduate basic and clinical program for practicing otolaryngologists. It is designed to bring to specialists current information in medical and surgical otorhinolaryngology.

Interested physicians should direct communications to: Department of Otolaryngology, P. O. Box 6998, Chicago, Illinois 60680.

Pan-Pacific Surgical Association Sets 10th Congress in Honolulu

The Pan-Pacific Surgical Association will hold its 10th Congress in Honolulu September 20 to 28 and is planning a Mobile Educational Seminar from September 28 to October 10 for Japan and Hong Kong, and from September 28 to November 1 for those who also wish to visit The Philippines, Thailand, India, Singapore, Australia and New Zealand.

For full particulars write the Association at Alexander Young Bldg., Honolulu 96813.

Joint Scientific Meeting Planned for San Francisco August 28-September 2

The American Congress and the American Academy of Physical Medicine and Rehabilitation will hold a joint scientific meeting and separate business meetings at the Sheraton-Palace Hotel, San Francisco, August 28 to September 2.

Social events are planned for each day in addition to special activities for the ladies auxiliary and supervised program for children.

Eighth National Conference on The Medical Aspects of Sports

The Eighth National Conference on the Medical Aspects of Sports, sponsored by the American Medical Association under the auspices of its Committee on the Medical Aspects of Sports, will be held in Las Vegas, Nevada, at Caesar's Palace on November 27. The conference is held annually in conjunction with and on the first day of the Clinical Convention of the American Medical Association.

The conference is open to key nonmedical athletic personnel as well as interested physicians. Those who would like to receive further information concerning the conference should address the Secretary, Committee on the Medical Aspects of Sports, American Medical Association, 535 N. Dearborn St., Chicago, Illinois 60610.

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Medical Director

James L. Hagle
Administrator

Technicon International Symposium on Automation to be October 17-19

The Technicon International Symposium on Automation in Analytical Chemistry will be held at the Statler-Hilton Hotel, New York City, on October 17, 18 and 19.

Write Jerome E. Golin, Technicon Instruments Corporation, New York City 10502 for further information.

Laryngology, Bronchoesophagology Course October 31 to November 12

The Department of Otolaryngology of the Illinois Eye and Ear Infirmary and the College of Medicine of the University of Illinois at the Medical Center, Chicago, will conduct a postgraduate course in laryngology and bronchoesophagology from October 31 through November 12.

This course is limited to fifteen physicians and will be under the direction of Paul H. Holinger, M.D. It will be held largely at the new Illinois Eye and Ear Infirmary, 1855 West Taylor Street, Chicago, and will include visits to a number of Chicago hospitals. Instruction will be provided by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures.

Interested registrants will please write directly to the Department of Otolaryngology, College of Medicine of the University of Illinois at the Medical Center, P. O. Box 6998, Chicago, Illinois 60680.

Course in Gastroenterology Offered in Philadelphia in October

The annual postgraduate course in Gastroenterology of the American College of Gastroenterology will be given at the Bellevue Stratford in Philadelphia on October 27 to 29.

The subject matter to be covered, from the medical as well as the surgical viewpoint, will be essentially the diagnosis and treatment of gastrointestinal diseases and comprehensive discussions of diseases of the esophagus, stomach, pancreas, liver and gallbladder, small intestine and colon. A session on instrument technics will be held at the Albert Einstein Medical Center.

For enrollment and more information write American College of Gastroenterology, 33 W. 60th St., New York City 10023.

AMA Congress on Occupational Health Will Meet in September

The AMA Congress on Occupational Health will meet this year in Portland, Oregon on September 26 to 28. It will be in conjunction with the annual session of the Oregon Medical Association, as it was with the ISMA annual convention last year.

Details are obtainable from the AMA Council on Occupational Health, 535 N. Dearborn, Chicago 60610.

American Medical Writers Will Meet in New York City

The American Medical Writers' Association will hold its annual meeting at the Waldorf Astoria, New York City, September 29 through October 2, 1966.

Theme for the meeting will be "The Changing World of Medical Communication." For a copy of the program write A.M.W.A., 2000 'P' St., N. W., Washington, D. C. 20036.

Kidney Foundation of Illinois to Conduct Postgraduate Training Program

The Kidney Foundation of Illinois will conduct a professional medical symposium postgraduate training program at the Sheraton-Chicago Hotel on October 5, from 9 a.m. to 5 p.m.

Outstanding authorities in the prostate and renal field, including three speakers from England, one from France and one from Australia, will present papers. The cost of $15.00 per person will include luncheon. Details may be obtained by writing Mr. John Lane, Executive Director, 127 N. Dearborn St., Suite 701, Chicago 60602.

ISMA Members Invited to Indiana Society OF Radiologic Technologists Annual Meeting

The Indiana Society of Radiologic Technologists will hold its 27th annual meeting in Muncie at the Van Orman-Roberts Hotel, October 6 to 8. Members of ISMA are invited to attend.

Refresher courses, guest speakers, scientific papers and exhibits will constitute the scientific portion of the program. Details may be obtained by writing Joan M. Duncan, R.T., Ball Memorial Hospital, Muncie 47304.

American Academy of Pediatrics Sets Annual Meeting for October 22-27

ISMA members are invited to attend the annual meeting of the American Academy of Pediatrics, at the Palmer House Hotel, Chicago, October 22 to 27. The scientific program will include lectures, seminars, roundtable discussions and meeting of the pediatric subspecialties.

Several awards will be made during the meeting, including two E. Mead Johnson Awards for outstanding pediatric research. Registration fee for non-members out of school more than five years is $50; all others, including physicians of Armed Forces, $16. Program, housing forms and registration forms are procurable by writing the Academy at 1801 Hinman Ave., Evanston, Illinois 60204.

Continued

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• Torpedoed on the Murmansk run —nearly frozen to death in an open boat—both legs lost below the knee—ex-Merchant Marines Michael McCormick and William Morris walked unaided in three weeks. They could look forward with certainty to leading a normal life again. To these men, as to thousands of other Hanger wearers, the phrase "Hanger is a symbol of help and hope" is a concrete truth proven by every day of their future lives.

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Postgraduate Course on "Cardiac Emergencies" Set for September 9 and 10 at Louisville

The Division of Continuation Medical Education of the University of Kentucky College of Medicine will conduct a postgraduate course—"Cardiac Emergencies" — September 9 and 10.

This course will be held at the University of Kentucky Medical Center and there will be a $30.00 registration fee. Six outstanding guest faculty in this field and members of the University of Kentucky faculty have been invited to participate.

For further particulars, write Nicholas J. Pisacano, M.D., Director, Continuation Medical Education, University of Kentucky, Lexington, Ky. 40506.

Postgraduate Conference on "The Mentally Retarded Child"

The University of Wisconsin will conduct a three-day postgraduate conference on "The Mentally Retarded Child," on April 6 to 8, 1967, at the University of Wisconsin Medical Center, Madison.

A faculty of distinguished pediatricians from U. S. and England will participate. ISMA members are invited to attend. Inquiries may be directed to Dr. Harry A. Waisman, 1300 University Ave., Madison, Wisconsin 53706.

Interstate Postgraduate Medical Association Scientific Assembly in October

The Interstate Postgraduate Medical Association will hold its 51st Annual Scientific Assembly at the Sheraton-Park Hotel, Washington, D. C., on October 17 to 20.

Details concerning the program and reservations may be obtained by writing the Association at Box 1109, Madison, Wisconsin 53701.

Flying Physicians Association Will Meet September 11 to 16

The Flying Physicians Association will meet at the Dunes Hotel in Las Vegas, Nevada, on September 11 to 16. Scientific sessions will be devoted largely to discussions of various medical disciplines as they relate to general aviation.

Membership is open to all licensed physicians who are members of medical societies approved by the board of directors. National membership now exceeds 1,800, of whom 117 belong to the Indiana chapter. Dr. Louis Byrne, Bloomington, heads the Indiana chapter.

Seminar on Diabetes Set for September 29-30 in Miami Beach

A Seminar on Diabetes will be conducted by the Florida Diabetes Association, at the Deauville Hotel, Miami Beach, on September 29 and 30. ISMA members are invited.

Write Dr. R. T. Rengarts, P.O. Box 268, Sebring 33870, for further details. ◄

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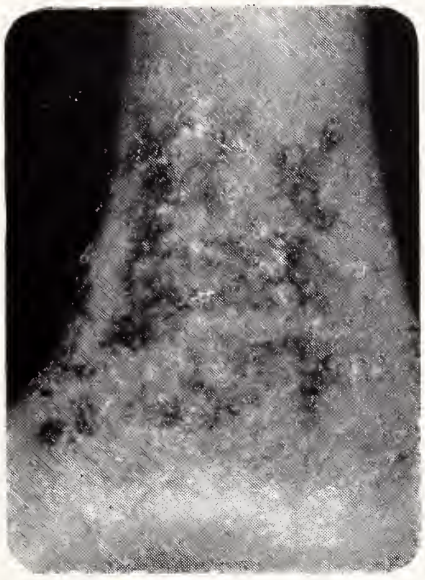
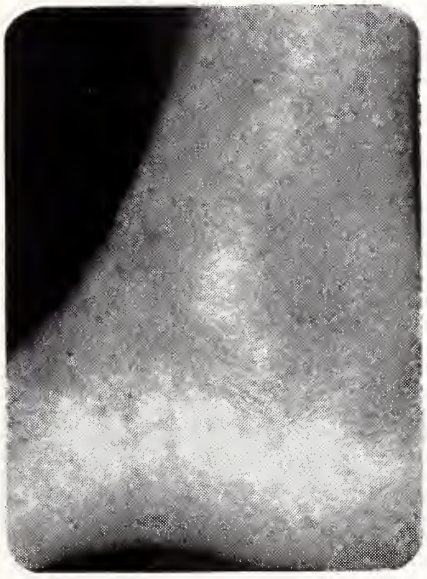


Before treatment



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ARISTOCORT® Triamcinolone Acetonide Topicals have proved exceptionally effective in the control of various forms of eczema: allergic, atopic, nummular, psoriatic, and mycotic.

In most cases responsive to topical ARISTOCORT, the 0.1% concentration is sufficiently potent. The 0.5% concentration provides enhanced topical activity for patients requiring additional potency for proper relief.

Administration and Dosage: Apply sparingly to the affected area 3 or 4 times daily. Some cases of psoriasis may be more effectively treated if the 0.1% Cream or Ointment is applied under an occlusive dressing.

Contraindications: Tuberculosis of the skin, herpes simplex, chicken pox and vaccinia.

Precautions and Side Effects: Do not use in the eyes or in the ear (if drum is perforated). A few individuals react unfavorably under certain conditions. If side effects are encountered, the drug should be discontinued and appropriate measures taken. Use on infected areas should be attended with caution and observation, bearing in mind the potential spreading of infection and the advisability of discontinuing therapy and/or initiating antibacterial measures. Generalized dermatological conditions may require systemic corticosteroid therapy. Steroid therapy, although responsible for remissions of dermatoses, especially of allergic origin cannot be expected to prevent recurrence. The use over extensive body areas, with or without occlusive nonpermeable dressings, may result in systemic absorption. Appropriate precautions should be taken. When occlusive nonpermeable dressings are used, miliaria, folliculitis and pyodermas will sometimes develop. Localized atrophy and striae have been reported with the use of steroids by the occlusive technique. When occlusive nonpermeable dressings are used, the physician should be aware of the hazards of suffocation and flammability. The safety of use on pregnant patients has not been firmly established. Thus, do not use in large amounts or for long periods of time on pregnant patients.

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County, District News

Seventh District

New officers of the Seventh District Medical Society are: Drs. Jay Reese, Martinsville, president; Harry E. Mock, Jr., Franklin, president-elect and James H. Gosman, Indianapolis, re-elected secretary-treasurer. Dr. John O. Butler, Indianapolis, was elected new alternate councilor.

Dearborn-Ohio

Dr. Bert McBride, neurosurgeon from Cincinnati, Ohio, spoke on "The Treatment of Various Head Injuries" at the June 2 meeting of the Dearborn-Ohio County Medical Society.

Dubois

Dr. Francis H. Gootee, Jasper, has been elected president of the Dubois County Medical Society, replacing Dr. Jack D. Bland, Holland, who is in service.

Fayette-Franklin

"Diagnosis and Treatment of Meningitis in the Newborn Infant" was the topic of Dr. Irwin Light, Cincinnati, when he spoke at the June 14 meeting of the Fayette-Franklin County Medical Society.

Knox

The Knox County Medical Society has elected the following as its new officers: Drs. Robert J. Nichols, president; Boyd K. Black, vice-president; Charles L. Miller, secretary and Ralph J. Jacqmain, treasurer. All of the new officers are from Vincennes.

Tippecanoe

Dr. Robert England spoke on "Non-Participation" at the June 14 meeting of the Tippecanoe County Medical Society. Fifty-one members attended. ◄

Deaths

R. Morton Bolman, M.D.

Dr. R. Morton Bolman, 50, Fort Wayne surgeon for more than 20 years, died May 20 following an illness of nearly eight months.

Dr. Bolman, a diplomate of the American Board of Surgery, had practiced in Fort Wayne since 1945. He served in Europe during World War II and was chief of general surgery of the 3,000-bed 108th General Hospital in Paris.

Graduated from the Northwestern University School of Medicine, Dr. Bolman formed the Bolman Surgical Associates in Fort Wayne and was a director of the Vita McNair Bolman Foundation, established to foster creative and fundamental medical research and improved medical facilities in Fort Wayne. He was named chairman of the department of surgery at St. Joseph's Hospital in 1948 and served on the hospital advisory board. Dr. Bolman was a member of the Allen County Medical Society.

Dallas Fickas, M.D.

Dr. Dallas Fickas, Evansville physician who compiled a medal-winning record as an Army surgeon in World War II, died July 3 at his home. He was 57.

Dr. Fickas was graduated from the I.U. School of Medicine in 1932 and did postgraduate work at the University of Pennsylvania. During World War II, he served in the European Theater throughout most of the war. He received four battle stars for his service in England, France, Belgium and Germany. Dr. Fickas was formerly president of the Vanderburgh County Medical Society and was a member of the City-County Health Board. He was also a member of the ISMA Commission on Medical Education and Licensure.

Wallace S. Grayston, M.D.

Dr. Wallace S. Grayston, 87-years-old, veteran Huntington physician and surgeon, died June 13 in Huntington County Hospital.

Dr. Grayston, graduated from the Northwestern School of Medicine in 1904, was a physician and surgeon for more than 50 years before he retired in 1953. Dr. Grayston, member of the Huntington County Medical Society, provided the impetus for the drive which resulted in the building of the present Huntington County Hospital. He was a Senior Member of ISMA and member of the 50-Year Club.

Frank M. Hall, M.D.

Dr. Frank M. Hall, 69-year-old Indianapolis physician, died June 24 in Methodist Hospital.

Dr. Hall, a native of Churubusco, had practiced medicine in Indianapolis since 1947. Graduated from the I.U. School of Medicine in 1926, Dr. Hall served in both World War I and World War II. He was a naval commander and was a member of the Marion County Medical Society.

C. S. White, M.D.

Dr. C. S. White, 85, of Rosedale, died June 28 in his home.

Graduated from the former Indiana Medical College, Dr. White began his practice in 1906 and retired in 1956. A veteran of World War I, he was a member of the Parke-Vermillion County Medical Society, the ISMA 50-Year Club and a Senior Member of ISMA. ◄

Association News

EXECUTIVE COMMITTEE

June 11, 1966

Present: Ralph V. Everly, M.D., chairman; Kenneth O. Neumann, M.D.; Eugene S. Rifner, M.D.; E. T. Edwards, M.D.; Ottis Olvey, M.D., Lester Hoyt, M.D.

Frank B. Ramsey, M.D., editor of *The Journal*; Robert Hollowell, attorney and James A. Waggener, executive secretary.

Membership Report

Number of members as of December 31, 1965	4,394
1966 members as of May 31, 1966:	
Full dues paying	3,828
Residents and interns	106
Council remitted	47
Senior	310
Honorary	3
Military	36
Total 1966 members as of May 31, 1966	4,330
Number of members as of May 31, 1965	4,316
Gain over last year	14

Number of AMA members as of May 31, 1966	4,212
Total 1965 AMA members as of May 31, 1965	4,214
Loss over last year	2
1966 AMA members: Dues paying	3,712
Exempt, but active	500
	4,212
Number who have paid state dues but not AMA dues as of May 31, 1966	118

Headquarters Office

Letter from Allen County Medical Society concerning membership matters and a resolution adopted by the Lake County Medical Society concerning membership matters were discussed by the legal counsel and upon motion of Drs. Neumann and Rifner, these matters are to be referred to the Commission on Constitution and Bylaws.

A statement from an ex-officio member of a commission for attending a national meeting was approved for payment, and the commission is to be instructed that in the future, ex-officio members are not to be sent to meetings without approval of the Executive Committee.

Building Matters

Report on the rental status of the Pennsylvania Street properties was given for the information of the committee.

Treasurer's Office

Report of the treasurer was accepted by consent.

Annual Convention, French Lick, October 10, 11, 12 and 13, 1966

By consent it was agreed to request Dr. E. S. Jones of Hammond to provide the response for the Fifty-Year Club.

The president discussed his treatment at other state medical conventions and suggested that at the July Council meeting, hosts for the visiting out-of-state presidents be appointed and that the auxiliary be requested to appoint hostesses for their wives if they accompany them.

Request of the Evansville MEDCOE group for exhibit space, advocating the establishment of a medical school in the Evansville area, was reviewed and the organization is to be informed that space will be available on a pay basis.

The secretary was instructed to notify other interested communities of the possibility of this organization exhibiting so that they may have an equal opportunity if they also desire to exhibit.

Legislation

National: The revised Keogh Bill, and the proposed welfare program for implementation of Title XIX were reviewed for the information of the committee.

Organization Matters

Copies of reprints of Medical Care of Compensation Cases in Indiana and report of the Commission on Public Health, reproduced by the Indiana State Chamber of Commerce from *The Journal* of the Indiana State Medical Association, were reviewed for the information of the committee.

Exchange of correspondence between the Ohio State Medical Association, the American Medical Association, and the Social Security Administration was reviewed for the information of the committee.

A letter from Mier Bizer, M.D., Jeffersonville, was reviewed and the secretary was instructed to thank Doctor Bizer for his suggestion.

Request of the Health and Hospital Corporation for use of the association mailing list to send out postgraduate programs was approved on motion of Drs. Neumann and Edwards.

A letter from Dr. Dan L. Urschel was read and the letter was accepted for information.

A letter distributed to Indiana physicians by the Veterans Administration concerning the new method of handling hometown patients was reviewed for the information of the committee.

Report of the Commission on Legislation was read and upon motion of Drs. Neumann and Olvey, the Executive Committee is to recommend to the members of the commission that they further investigate this matter and press for any necessary changes.

A letter from Dr. John R. Thompson was read for the information of the committee.

The proposed recommended changes in regulations of the Hospital Licensing Council were reviewed and were approved for transmission to Dr. Offutt.

Minutes of the State Board of Medical Registration and Examination were reviewed for the information of the committee.

The program, Partners of the Allianee, was not discussed in detail but the principle of the program was approved. However, by consent it was voted that no money be given to this project.

Correspondence from the Tennessee State Academy of Ophthalmology and Otolaryngology was reviewed and the secretary was instructed to send copies of this material to the Indiana Academy of Ophthalmology and Otolaryngology.

New Business

Matters pertaining to the AMA convention were deferred for discussion before the Council.

The proposal of the Indiana National Bank for ready-credit for Medicare patients, Indianapolis area, was discussed and by consent it was agreed that this should not be a project of the Indiana State Medical Association inasmuch as it will apply only to Marion county residents and the sponsorship of this plan should be offered to the Marion County Medical Society.

The Journal

Request of the Health and Welfare Fund of the AFL-CIO Teamsters Union for a copy of the roster of the Indiana State Medical Association was approved by consent.

Future Meetings

The invitation to the members of the Executive Committee to attend the delegates' dinner of the AMA was read. Inasmuch as no interest was expressed, no action was taken.

The Conference on M.D. Placement, to be held in Chicago, June 28, 1966, was noted and no action taken.

An invitation to the secretary to attend the program of the Medical Exhibitors' Association was approved by consent.

Notice of the AMA Rehabilitation Conference, to be held in Chicago on September 8 and 9, 1966, was read. No action was taken. This matter is to be placed on the agenda for the July Executive Committee meeting.

Upon motion of Dr. Olvey, taken by consent, the field men were authorized to attend the AMA convention in Chicago on Tuesday, Wednesday and Thursday, June 28, 29 and 30, 1966.

There being no further business the Executive Committee adjourned, to meet again at 6:30 p.m., Sunday, June 26, 1966, at the Palmer House, Chicago, for further discussion with the AMA delegates concerning AMA matters.

THE COUNCIL

June 12, 1966

The Council of the Indiana State Medical Association convened in a special session at 10:00 a.m., Sunday, June 12, 1966, in the headquarters office, 3935 North Meridian Street, Indianapolis, with Dr. E. T. Edwards, the chairman, presiding.

Roll call showed the following present:

Councilors:

First District — P. J. V. Corcoran, Evansville
Second District — E. T. Edwards, Vincennes
Third District — Donald M. Kerr, Bedford
Fourth District — Jack E. Shields, Brownstown, alternate (also AMA delegate) *
Fifth District — V. Earle Wiseman, Greencastle
Sixth District — Not represented
Seventh District — Albert M. Donato, Indianapolis
Eighth District — Donald R. Taylor, Muncie
Ninth District — Peter R. Petrich, Attica
Tenth District — Lowell H. Steen, Whiting
Eleventh District — Lowell J. Hillis, Logansport
Twelfth District — Milton F. Popp, Fort Wayne
William R. Clark, Fort Wayne, alternate
Thirteenth District — Not represented

Officers:

Kenneth O. Neumann, Lafayette, president
Eugene S. Rifner, Van Buren, president-elect
Ottis N. Olvey, Indianapolis, treasurer
Lester H. Hoyt, Indianapolis, assistant treasurer
Frank B. Ramsey, Indianapolis, editor, *The Journal*

Executive Committee:

Ralph V. Everly, Indianapolis, chairman

AMA Delegates:

Harold C. Ochsner, Indianapolis
E. S. Jones, Hammond
Francis L. Land, Fort Wayne
Guy A. Owsley, Hartford City
*Jack E. Shields, Brownstown

AMA Alternate Delegates:

James H. Gosman, Indianapolis
Robert M. Brown, Marion
Maurice E. Glock, Fort Wayne
Dwight W. Schuster, Indianapolis

AMA Trustee:

Lester D. Bibler, Indianapolis

The president brought several matters to the attention of the Council for its consideration:

1. That the Council consider making the commissions and committees responsible to the Council rather than to the House of Delegates, which would thereby have the commissions and the committees reporting to the Council on a regular basis rather than waiting for an annual report to the House of Delegates. This would serve to better inform the Council of the activities of the association and would relieve the House of Delegates of many matters. Any matters which are brought to the Council by the commissions and committees could be sent to the House of Delegates upon recommendation of the Council.

2. That the Council give thought to recommending to the Commission on Constitution and Bylaws that the sections of the association be permitted to have a delegate to the ISMA House of Delegates.

3. That the reference committees of the House be numbered rather than titled by subjects, as now provided for in the bylaws, which would give more flexibility in assigning resolutions and would help to equalize the load of the reference committees.

Dr. Neumann reviewed his experiences in attending the district meetings and the meetings of adjoining state medical societies.

The president also commented that it was his feeling that other states are more selective in the choosing of their AMA delegates and alternates and perhaps the Indiana State Medical Association should get away from the geographical representation and obtain representation on the AMA level of men well qualified for these important positions.

The president also called for the Blue Shield Liaison Committee of the Council to be complimented by the Council for its fine work, and he asked that the Council reevaluate the I-HOPE organization.

Dr. Popp commented that the Council should go on record as proclaiming that the physicians of Indiana will do their best for their patients under PL 89-97, that physicians should obey the law, but that PL 89-97 is a bad law.

Matters Referred to Council by Executive Committee

The chairman of the Executive Committee referred to the Council the resolutions and letter from the Allen County Medical Society concerning the constitutionality of PL 89-97. This matter was discussed thoroughly by many, and **on motion of Drs. Petrich and Steen, the Council voted that the Allen County resolutions are not to be recommended to the AMA delegation for presentation to the AMA House of Delegates.**

The chairman of the Executive Committee also reported that the Executive Committee recommended Dr. E. S. Jones to give the Fifty-Year Club response at the annual convention banquet. **This was approved on motion of Drs. Popp and Taylor.**

The chairman reported that MEDCOE of Evansville had requested exhibit space for the French Lick convention and that the Executive Committee recommended that this organization be permitted to exhibit in a paid space. **On motion of Drs. Kerr and Popp, it was voted that MEDCOE be accepted as an exhibitor in a paid space.**

Report of President-elect

The president-elect then was called upon and he spoke on resistance to PL 89-97 and he re-emphasized the importance of selection of AMA delegates and alternate delegates and discussed the change-over of radiology and pathology matters.

Radiology and Pathology Matter

Reports on the efforts of radiologists and pathologists to change over to an independent status were made by Drs. Donato, Steen and Taylor.

AMA Dues Increase

The proposed increase in AMA dues was discussed and the AMA delegates reported on the response they had received to the letters sent to the county medical societies asking for their opinions on this subject. **On motion duly made and seconded, the Council voted that the AMA delegates be instructed to vote Indiana as approving the AMA dues increase. On a standing vote the motion was lost, 6 to 5.**

This matter was further discussed and **upon motion of Dr. Shields, the Council voted to reconsider its previous action. On motion of Drs. Shields and Olvey, it was voted that the Indiana State Medical Association support the AMA dues increase. This motion carried, 7 to 3.**

On motion of Drs. Steen and Shields, the Council voted that the AMA delegates present a resolution before the House of Delegates at the June meeting of the AMA requesting that a committee of the House of Delegates of the AMA be created to conduct a full investigation of the activities and finances of the AMA.

PL 89-97

The delegates then reviewed the resolutions to come before the AMA and **on motion of Drs. Steen and Popp, the delegates were instructed to work for an amendment to resolution No. 19.**

On motion of Drs. Neumann and Taylor, taken by consent, the delegates are to present the name of Dr. E. S. Jones of Hammond as a candidate for the office of vice-president of the AMA, and are to support Dr. John H. Budd of Cleveland, Ohio, for the position of vice-speaker of the House of Delegates of the AMA.

Dr. Corcoran moved that the AMA delegates be instructed to work for reimbursement under PL 89-97 under Part B on the basis that the requirement of a receipted bill be eliminated. The motion was lost for want of a second.

Dr. Corcoran recommended that the Council should consider seriously the emergency room problems in the various hospitals.

Medical Ethics

The Council then considered a resolution concerning the ethics and **upon motion of Drs. Rifner and Steen, the following resolution was adopted:**

WHEREAS, The House of Delegates and the Council has repeatedly stated that the corporate practice of medicine is illegal and the Supreme Court has upheld this, and

WHEREAS, only the independent practice of medicine has been held to be a symbol of free enterprise, and

WHEREAS, national medical organizations have stated that their members should not practice under contracts or other arrangements which place or lend support to placing hospitals in the corporate practice of medicine, and

WHEREAS, the House of Delegates of the Indiana State Medical Association has repeatedly requested the transfer of the payment for professional services from Blue Cross to Blue Shield, and from other carriers as well, and

WHEREAS, under our principles of ethics a physician may not let a corporation sell his services, and he is to obey all laws,

NOW THEREFORE BE IT RESOLVED, that the Council of the Indiana State Medical Association considers it unethical for any member of the association to practice in a manner other than in accord with the above principles, and

BE IT FURTHER RESOLVED, that the Council of this association calls upon physician members of medical staff liaison committees with hospital administrations to support this position, especially the position of hospital-based specialists attempting to make such appropriate changes, and

BE IT FURTHER RESOLVED, that the Indiana State Medical Association Council encourage open staff departments of radiology, pathology, physiatry, and anesthesiology by competently trained members of the staff.

The secretary was ordered to distribute copies of this resolution to all county medical societies.

Dr. Olvey presented, on behalf of Dr. Donato, the following resolution:

As a result of the Indiana Hospital Association Bulletin of June 9, 1966, it is obvious there has been no effort to rescind the resolution of the IHA pertaining to hospital-based specialists; therefore I move that the Council demand of the IHA a recission of this resolution and authorize the attorneys to proceed as necessary if the request is refused.

Dr. Corcoran moved to table the above resolution, and the motion was carried.

The Council then discussed the proposed changes in the regulations of the Hospital Licensing Council. **The motion of Drs. Hillis and Corcoran that the report of the Executive Committee and the proposed changes in the Hospital Licensing Council regulations be rejected was put to a vote, and lost.**

It was moved by Dr. Neumann, seconded by Dr. Steen, that the suggested revisions be accepted; motion put to vote, and carried.

Dr. Steen then presented a report concerning the Blue Shield program which brought out the fact that Blue Shield had not heard from a number of physicians over 65 concerning a change-over to one of the supplementary plans. The Council Liaison Committee with Blue Shield had recommended to Blue Shield that if it did not hear from these physicians that they should automatically transfer them to Option III. **The report was approved on motion of Drs. Neumann and Corcoran.**

The proposal of the Indiana National Bank for the ready-credit program for people over 65 was discussed **and Drs. Steen and Neumann moved that all reference to the Indiana State Medical Association be deleted and that this matter be referred to the Marion County Medical Society. Motion duly seconded, put to vote, and carried.**

There being no further business the Council adjourned to meet again at 10:00 a.m., Sunday, July 17, 1966. ◄

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NOTICE

Commercial announcements are carried in the Journal as a special service to ISMA members. Only advertisements considered to be of advantage to members by the Journal editorial board will be accepted. Those of a truly commercial nature (i.e., firms selling brand products, services, etc.) will be considered for display type advertising.

Charges for commercial announcements are:

First four lines: $3.00
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Send cash with order. Average count: seven words to the line.

DEADLINE: Fifth day of month PRECEDING month of issue.

SPECIAL NOTICE

June issues and the 1966-67 Roster may be obtained from the JOURNAL, 3935 N. Meridian, Indianapolis 46208.

Roster: $3.00 each.

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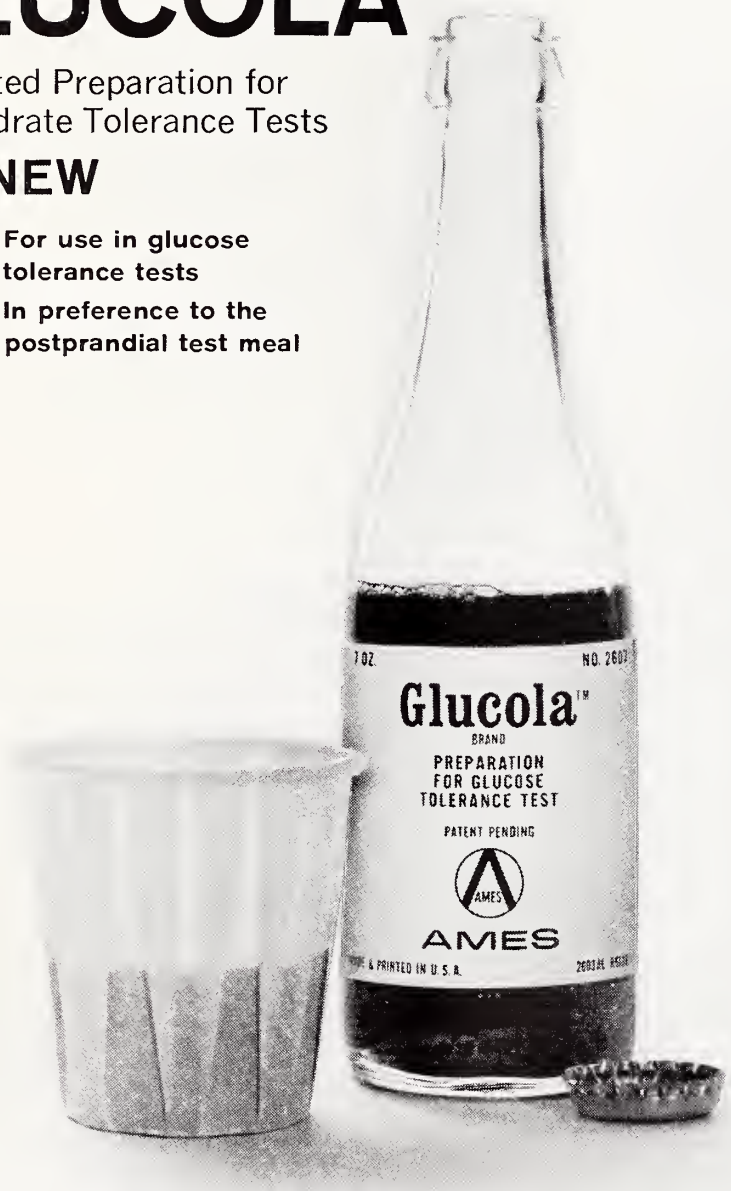

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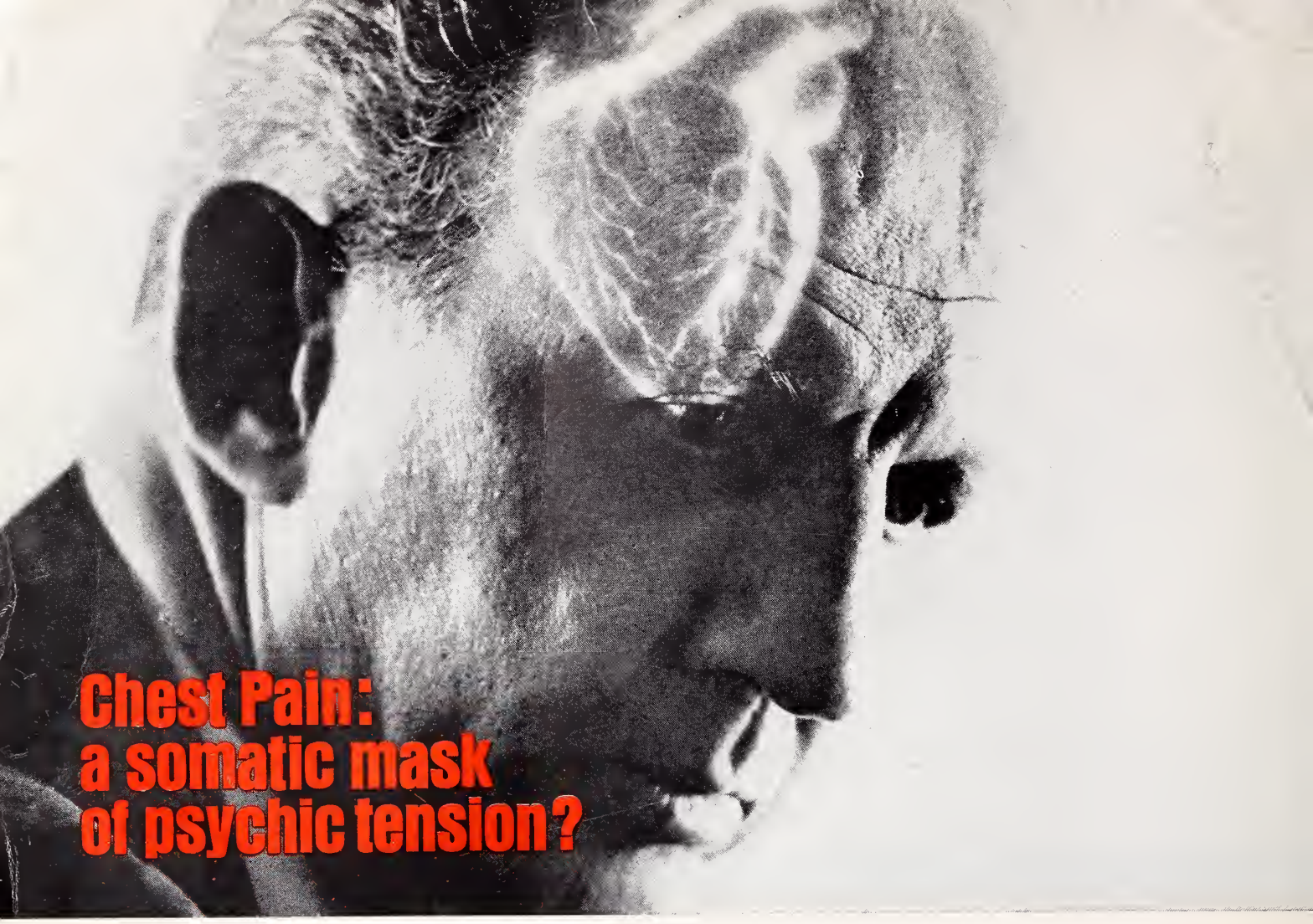

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Entered as secand class matter January 25, 1933, at the Pastoffice at Indianapalis, Indiana. Copyright, 1965, by the Indiana State Medical Association. Published monthly at 3935 N. Meridian, Indianapolis 46208.

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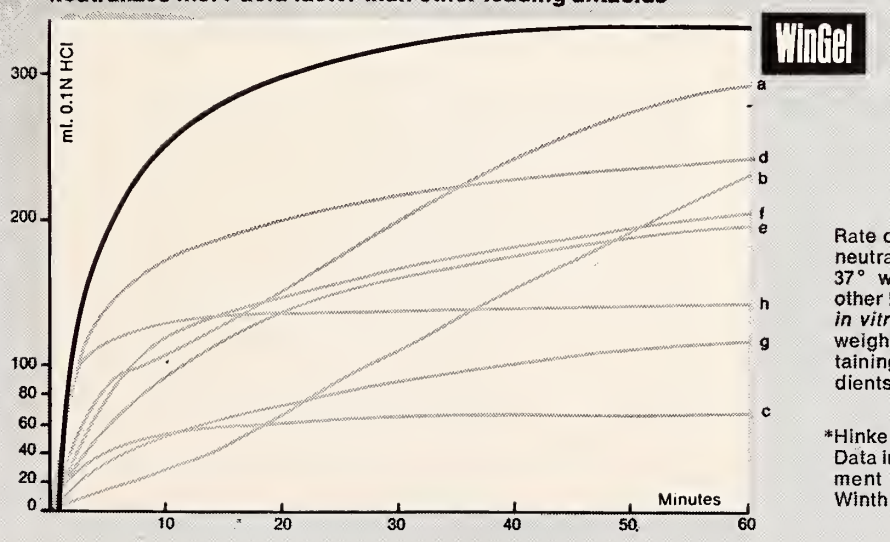

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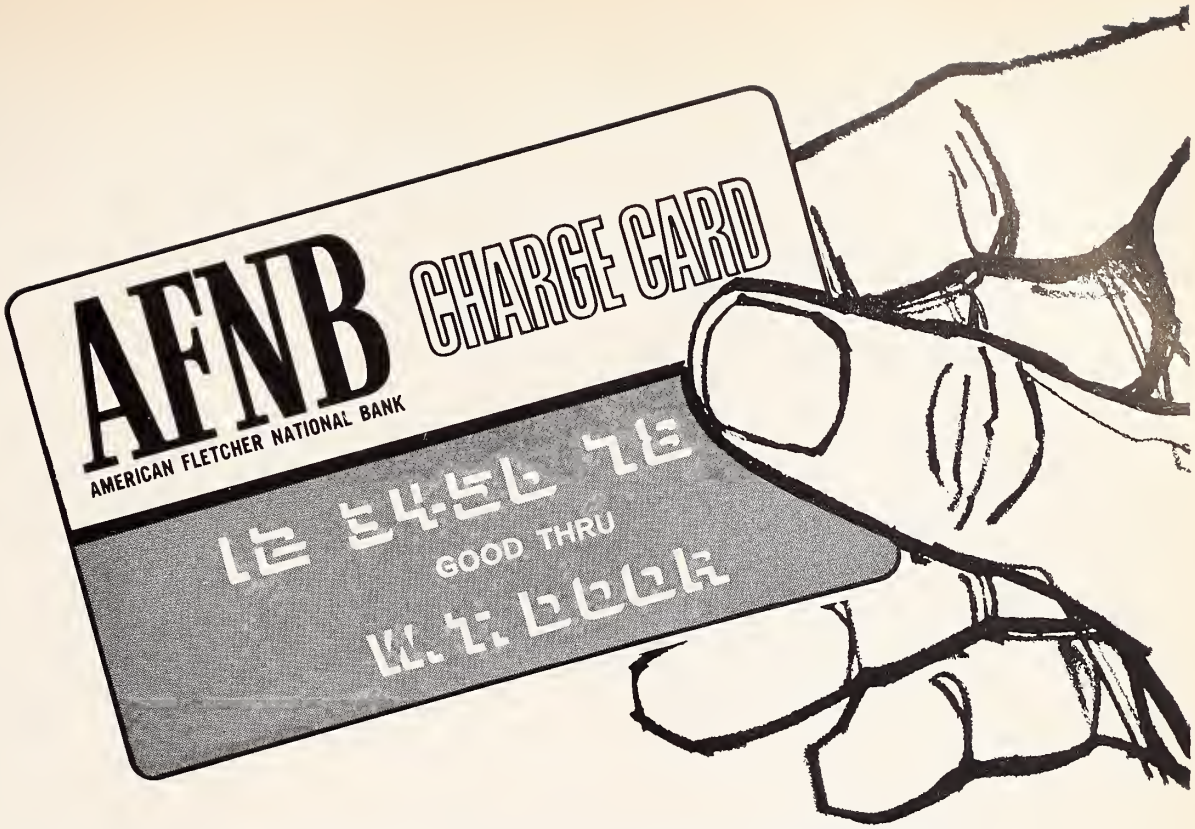

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summer 1966

DORSEY Season

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this issue: emergency anesthesia and the common cold

When emergency anesthesia is complicated by the common cold

Barry Belonsky, M.D., F.A.C.A.
Staff Anesthesiologist, Hospital of The Albert Einstein College of Medicine, New York City

Medical facilities are often presented with unfamiliar patients who have unknown health histories. This is particularly true in emergency situations that arise due to accidents or acute illnesses. These cases may need prompt care requiring anesthesia, and if they involve colds, nasal allergies or other upper respiratory infections, can account for many complications which make up a major hazard during emergency anesthesia.

Administration of general anesthesia to a patient with a cold or upper respiratory infection is a hazardous undertaking. It should be avoided if at all possible. Indeed, the presence of U.R.I. is good reason for postponement of elective surgery.[1] In emergency surgery, regional or local block should be considered, but if general anesthesia is mandatory, it should be approached with utmost caution.

Since the attitude of "emergency surgery — hurry" has been replaced by "emergency surgery — watch out",[2] a knowledge of the complications is a great help in preventing them. Here is a brief outline of the problems involved and their treatment. Prevention of the complications is discussed later.

Complications during the induction of anesthesia

Most of the complications are a direct result of secretions and some a result of accompanying secondary infection. For example, *airway obstruction* due to excessive secretions occurs very commonly and is the direct effect of the cold. Respiratory exchange may be obstructed at any time during anesthesia because of excessive secretions, but is most likely to occur during induction. Suction apparatus must be available to overcome this.[3]

Excess secretions which stimulate and irritate the epiglottis and vocal chords can cause *laryngeal stridor and obstruction*. This can lead to complete laryngeal closure with resultant anoxia and death.

Bronchospasm and laryngospasm can result from secretions penetrating the bronchi and bronchioles. In laryngospasm, there are both inspiratory and expiratory stridor and difficulty in inflating the chest; in bronchospasm there is an expiratory wheeze, but not as much difficulty in inflation, although some resistance may be felt. Stridor is due to partial or complete closure of the vocal cords in spasm and the "crowing" sound is almost pathognomonic.

Secretions obstruct the nasal airways. This produces *difficulty in ventilation* through the mouth until the patient is deep enough to place an oral airway. An intravenous agent can be given to facilitate the induction of anesthesia.

Difficulties can arise if intubation is performed to ventilate the patient. For example, teeth can be broken by too vigorous attempts at intubation, or the intubation itself may be technically difficult due to secretions obstructing the view of the glottis. The postoperative sequelae of intubation ranges from mild laryngitis to pneumonia with atelectasis, and are seen far more commonly in patients suffering from colds than in normal patients.

Successive stages of laryngospasm which produce the characteristic stridor or "crowing" sound.

Progression of bronchioles into bronchospasm.

Complications during the maintenance of anesthesia *Bronchospasm* can occur in an unintubated patient due to secretions entering the bronchial tree from above, and acting as an irritant to the bronchi and bronchioles. Secretions accumulate quickly and the patient has to be suctioned continually. The whole cycle of coughing, bucking, laryngospasm and bronchospasm may ensue. The difficult decision here is whether it is better to suction the patient continually or to use an endotracheal tube which protects the cords and bronchi but introduces the risk of attendant complications.

Postoperative complications Postoperatively, complications can be more serious than even the intraanesthesia complications, and occur much more frequently in a patient who has been intubated.[4]

Sore throat and pharyngitis can result both from the preoperative upper respiratory infection and from the drying of the mucous membranes which occurs during anesthesia.

Tracheitis and bronchitis often result from secretions trickling down the tracheobronchial tree.

Laryngitis is frequently seen in patients with upper respiratory infections who have been intubated. There is a significant increase in the incidence of laryngitis compared to that in patients without upper respiratory infections.

Subglottic edema is a condition which occurs mainly in children who have been intubated. This pathology results from an exudate developing in the areolar tissue just below the cords. Because of the small size of the child's trachea, even a 1 mm increase in size of the mucous membrane can severely impair the air passage. Children exhibit this by severe expiratory stridor and may even become cyanotic. This may so severely embarrass the child's breathing that it must be treated vigorously. Most authorities agree on the treatment[5,6,7,8] consisting of a high oxygen concentration in the inspired air (60%), plus high humidity (close to 100%). Adequate parenteral fluid intake and slight cooling of the body temperature (by a cooled oxygen tent) also help in mild cases. In severe cases, there may be hypoxia which increases the restlessness and the oxygen demand rises. Sedation is often necessary, although concomitant depression of the respiratory center is undesirable. An antihistaminic accomplishes this purpose well, and adds sedation. Since there is always a possibility that an allergic response plays a role in edema, some relief of the respiratory distress may occur. Steroids should be used to control inflammatory and allergic phenomena and swelling. If all this fails, and the patient is still restless and hypoxic, a tracheostomy should be performed immediately.

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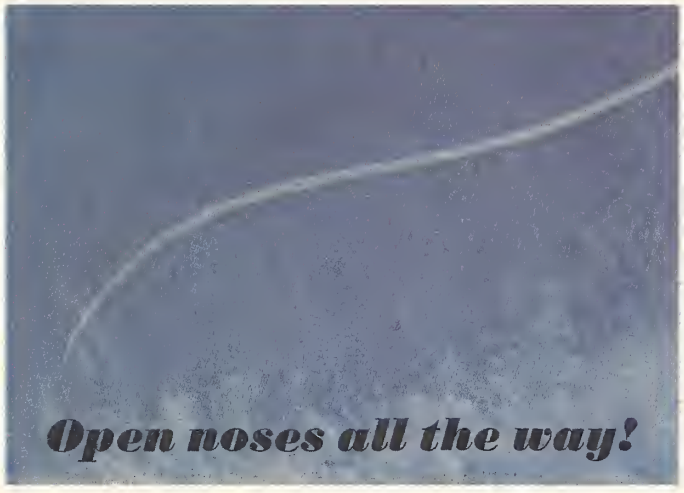

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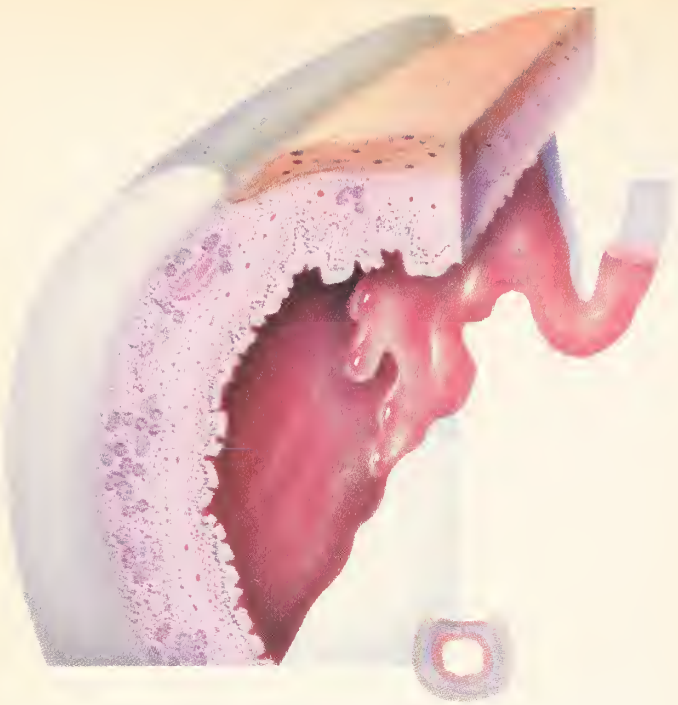

Cross section of trachea showing subglottic edema and lumen reduction due to mucous membrane congestion.

Pneumonia may also follow anesthesia administered to a patient with a cold. This can be caused by accumulated secretions becoming secondarily infected and causing consolidation of the lung. *Atelectasis* of the lung can result if one of the bronchioles becomes plugged by secretions, preventing aeration of the distal part of that lung. This is seen more frequently following upper respiratory infection because dry anesthetic gases aggravate the infection, causing secretions to change from watery to thick and viscid, and consequently difficult to suction.

Prevention of complications

The first rule to prevent complications, of course, is to use a regional or local anesthesia whenever possible. But when emergency surgery is a must, in spite of the presence of a cold, allergy, or upper respiratory infection, here are some ways to prevent complications.

Give nose drops preoperatively. This can help shrink the congested nasal mucous membranes and reduce secretions for better air passage. (Results of this method are sometimes unsatisfactory because of the short duration of effect or rebound congestion.) For longer effect, oral antihistamines with nasal decongestants are often given to provide and maintain a drying effect on secretions.

To clear the tracheobronchial tree, instruct the patient to cough preoperatively. Cold steam or water nebulizers effectively humidify the nasal, pharyngeal and bronchial passages and often make the patient more comfortable. Tenacious secretions become more watery under humidification, clear more thoroughly preoperatively and are more easily suctioned from the airway during anesthesia.

Give intravenous fluids to those patients who appear dehydrated due to a cold. In a well hydrated patient the respiratory tract secretions are less viscid and more watery. This is particularly true in asthmatics.

Summary:

Administration of emergency anesthesia to a patient with a cold or upper respiratory infection can lead to a chain of events that may result in increased postoperative morbidity and even death. This is because of the excess secretions formed in these conditions. Preoperative measures to prevent or reduce these secretions should be undertaken and will result in smoother and safer anesthesia.

References

1. Ellis, G.: Anesthesia and the Common Cold, Anesthesia, 1955, Vol. 10, p. 78. 2. Smith, R. M.: Anesthesia for Infants and Children, 1963, p. 353. 3. Gillespie, Noel A.: Endotracheal Anesthesia, 1963, p. 155 et seq. 4. Smith, R. M.: Anesthesia for Infants and Children, 1963, p. 353. 5. Written, F. W.: Postoperative Laryngeal Stridor, British Journal of Anesthesia, 1966, Vol. 38, p. 73. 6. Snyder & Gants: Respiratory Obstruction at the Glottic Level, Anesthesiology, 1953, Vol. 14, p. 195. 7. Doming, M. V. & Oech, S. R.: Steroid and Antihistaminic Therapy for Postintubation Subglottic Edema in Infants and Children, Anesthesiology, 1961, Vol. 22, p. 933. 8. Gillespie, Noel A.: Endotracheal Anesthesia, 1963, p. 118.

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Dosage: Adults—2 teaspoonfuls; Children 6 to 12 years—1 tsp.; Children 1 to 6 years—½ tsp. Administer every four hours. Side effects: Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness, or gastrointestinal upsets. Precautions: The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

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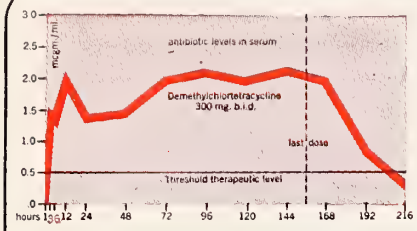
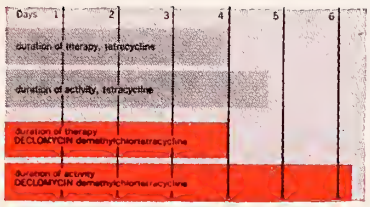


high activity

From Sweeney, W. M., Dornbush, A. C., and Hardy, S. M.: Amer. J. Med. Sci. 243 296 (Mar.) 1962



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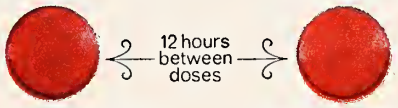

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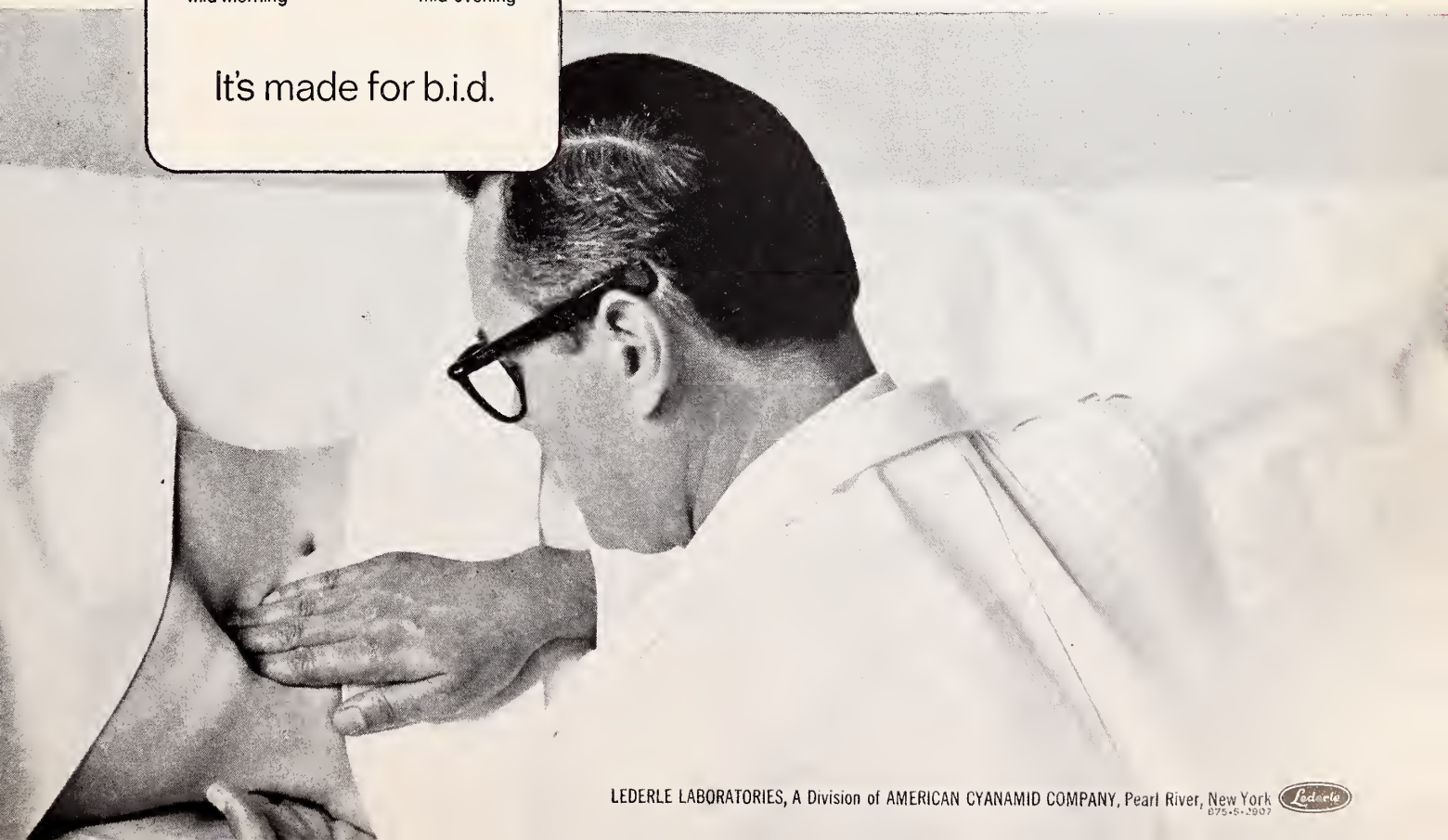
Contraindication—History of hypersensitivity to demethylchlortetracycline.

Warning—In renal impairment, usual doses may lead to excessive systemic accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort.

Precautions and Side Effects—Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. Use of demethylchlortetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect occurs mostly during long-term use but has also been observed in short treatment courses. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment. Side reactions include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and dermatitis. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Anaphylactoid reactions have been reported.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products.

Capsules: 150 mg; *Tablets:* film coated, 300 mg, 150 mg, and 75 mg of demethylchlortetracycline HCl.



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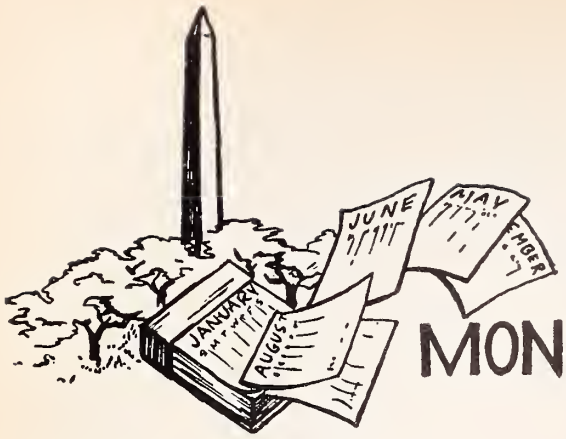


This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

MONTH IN WASHINGTON

WASHINGTON, D.C.—The Public Health Service Advisory Committee on Immunization has concluded that routine typhoid fever vaccination is not needed any longer in the United States.

SURGEON GENERAL William H. Stewart accepted the findings of the committee and stated as PHS policy that immunization against the disease is not recommended on a routine basis.

THE COMMITTEE reported that the incidence of typhoid in this country had declined steadily for many years and now is less than 500 cases a year. A continuance of the downward trend was predicted.

"CASES are sporadic and are primarly related to contact with carriers rather than to common source exposure," the committee said. "Recognizing this epidemiologic pattern of typhoid fever, redefinition of the role and use of typhoid vaccine is indicated."

THE COMMITTEE further stated that, "although typhoid vaccine has been suggested for individuals attending summer camps and those in areas where flooding has occurred, there are no data to support the continuation of these practices."

HOWEVER, select immunization was recommended in the following situations:
—Intimate exposure to a known typhoid carrier as would occur with continued household contact.
—Community or institutional outbreaks of typhoid fever.
—Foreign travel to areas where typhoid fever is endemic.

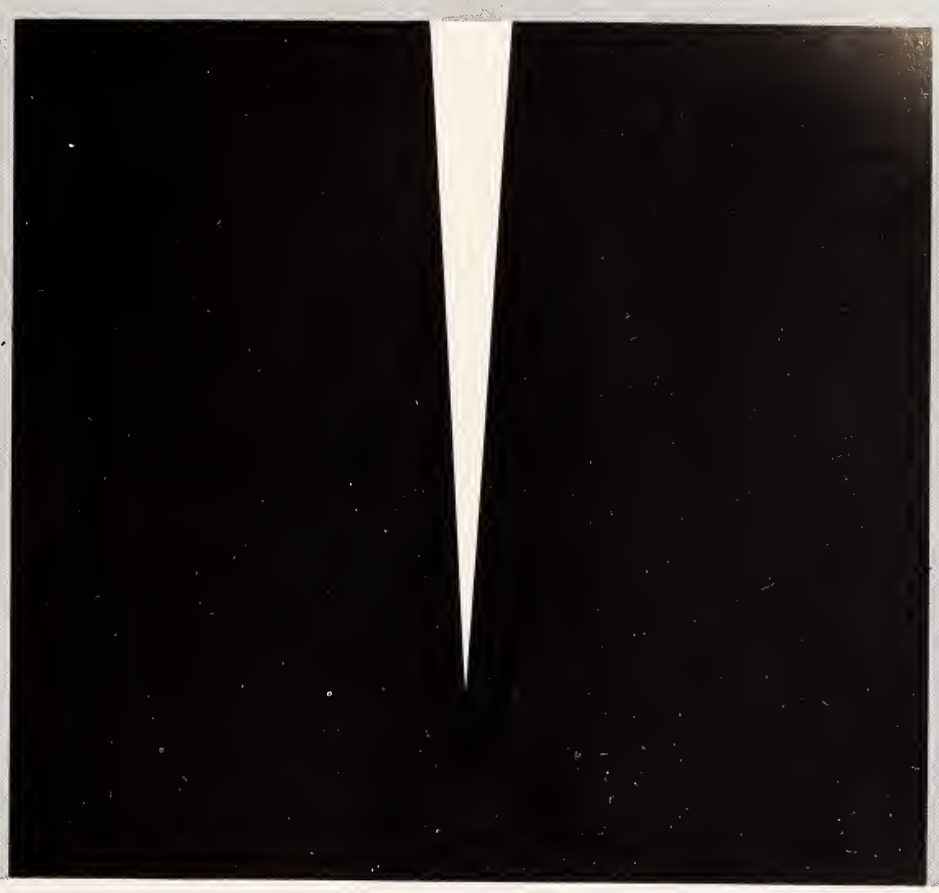
IN a separate report, the advisory committee predicted relatively little influenza during the 1966-67 season, but recommended vaccination after Sept. 1 for certain high-risk groups — such as the chronically ill and older persons.

THE COMMITTEE pointed out, however, that it is reasonable to expect that limited outbreaks of Type A_2 influenza will occur in parts of the United States not experiencing Type A disease in 1964-65 or 1965-66. Similarly, the possibility of some Type B influenza is recognized, particularly in the southwest.

"VACCINATION when called for should begin as soon as practicable after September 1 and ideally should be completed by mid-December," the committee said. "It is important that immunization be carried out before influenza occurs in the immediate area since there is a two-week interval before development of antibodies."

BECAUSE variations in influenza viruses during the 1965-66 season were not of

Continued on page 994.



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And 'Stelazine' offers additional benefits. Dependence has not been reported. At low doses, side effects are minimal. Its b.i.d. dosage is convenient and economical.

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The following is a brief precautionary statement. Before prescribing, the physician should be familiar with the complete prescribing information in SK&F literature or *PDR*. *Contraindications:* Comatose or greatly depressed states due to C.N.S. depressants and in cases of existing blood dyscrasias, bone marrow depression and liver damage. *Precautions:* Use with caution in angina patients and in patients with impaired cardiovascular systems. Antiemetic effect may mask symptoms of other disorders. An additive depressant effect is possible when used with other C.N.S. depressants. Prolonged administration of high doses may result in accumulative effects with severe C.N.S. or vasomotor symptoms. Use in pregnant patients only when necessary for the patient's welfare. *Side Effects:* Occasional cases of mild drowsiness, dizziness, mild skin reactions, dry mouth, insomnia and amenorrhea. Neuromuscular (extrapyramidal) reactions (motor restlessness, dystonias, pseudo-parkinsonism) may occur and, in rare instances, may persist. In addition, muscular weakness, anorexia, rash, lactation, hypotension, and blurred vision have been observed. Blood dyscrasias and cholestatic jaundice have been extremely rare.

For a comprehensive presentation of 'Stelazine' prescribing information and side effects reported with phenothiazine derivatives, please refer to SK&F literature or *PDR*.

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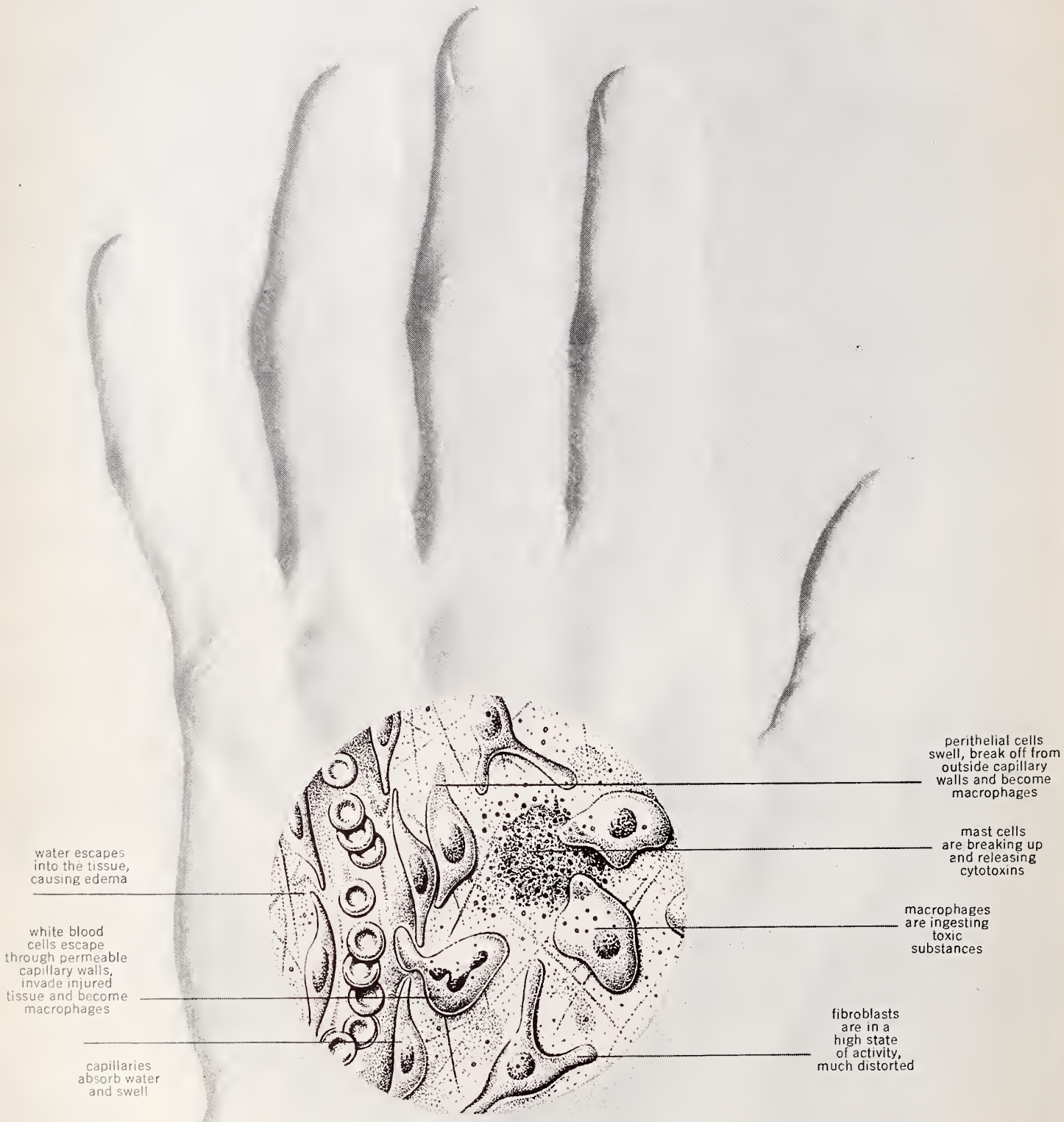

Inflammatory reaction after injury

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In inflammatory dermatoses choose a steroid synthesized specifically for topical use. Synalar (fluocinolone acetonide) provides therapeutic results often comparable to those of systemic and intralesional corticosteroids with fewer hazards.[1-3]

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For initiation of therapy: Cream 0.025%, 5 and 15 Gm. tubes, 425 Gm. jars; **for emollient effect:** Ointment 0.025%, 15 Gm. tubes; **for maintenance therapy:** Cream 0.01%, 15 Gm. tubes, 45 Gm. tubes, 120 Gm. jars; **for intertriginous or hairy sites:** Solution 0.01%, 20 cc. and 60 cc. plastic squeeze bottles; **for infected inflammatory dermatoses:** Neo-Synalar® Cream (0.025% fluocinolone acetonide, neomycin sulfate, equivalent to 0.35% neomycin base), 5 and 15 Gm. tubes.
Contraindications: Tuberculous, fungal, and most viral lesions of the skin, (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of its components. **Precautions:** Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. The neomycin in Neo-Synalar Cream rarely produces allergic reactions. Prolonged use of any antibiotic may result in overgrowth of nonsusceptible organisms; if this occurs, appropriate therapy should be instituted. Where severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. **Side Effects:** Side effects are not ordinarily encountered with topically applied corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions.

References: 1. Kanee, B.: Canad Med Ass J 88:999 (May 18) 1963. 2. Scholtz, J. R.: Calif Med 95:224 (Oct.) 1961. 3. Jansen, G. T., Dillaha, C. J., and Honeycutt, W. M.: Arch Derm 92:283 (Sept.) 1965.

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Continued

major significance, the composition of the 1966-67 vaccine is unchanged from that prepared for 1965-66.

NO DRASTIC CURBS ON USE OF PESTICIDES

A SENATE GOVERNMENT Operations Subcommittee said that more information is needed in the field but that scientific data now available does not indicate human health hazards of sufficient significance to warrant drastic curbs on the use of pesticides.

HOWEVER, the subcommittee reported that "the magnitude of the future risk is uncertain in many important areas."

"KNOWLEDGE REGARDING the risk of chemical pesticides . . . will have to be broadened and refined considerably in order to provide clear-cut answers to questions that will be forced by the increasing need for pest control in the future," said a subcommittee report based on a two-year study.

"WHILE SOME of the more gloomy prophecies that had been raised could not be supported by hard scientific fact, it is also true that science could not and still cannot prove that some of these prophecies are untenable."

TO COMBAT the human health dangers, the report recommended that the Department of Health, Education and Welfare, accelerate an environmental health program; increased research in human pharmacology; development of safer chemical pesticides which are safer for human beings; greater emphasis on development of non-chemical pest-control methods; training of agricultural workers in good hygiene practices in using pesticides; and general educational programs on health in the chemical age.

AMERICANS EATING TOO MUCH FAT

THE FOOD and Nutrition Board of the National Academy of Sciences believes that it may be well for many Americans to moderately reduce the amount of fats they eat and substitute some polyunsaturated for saturated fats.

HOWEVER, the board concluded in a lengthy report, "Dietary Fat and Human Health," that present evidence on the connection between dietary fat and cardiovascular diseases is insufficient to warrant recommendations for radical dietary changes.

THE BOARD'S STUDY was directed to the problem of how much and what kind of fat is compatible with human health. The report emphasized that any changes in consumption of fat should be made on an individual basis with consideration given the consequent changes in caloric and nutrient intake.

"UNTIL we learn more about which fats are desirable nutritionally the board recommends that the American consumer should partake of the foods that make up a varied, adequate, and not overly rich diet and maintain a normal body weight by judicious control of caloric intake and by daily exercise," the report said.

"A LARGE AMOUNT of information has accumulated relating dietary fats to the etiology of human atherosclerosis and its complications, particularly coro-

Continued

Breast-feeding and the "modern mother"

Despite a mild resurgence of interest in the importance of breast-feeding a few years ago, many women today do not choose to nurse their young. This is for a variety of reasons—social, economic, cultural and sometimes medical. In such cases the physician's task is to find the most suitable means of preventing lactation and easing the pain of breast engorgement.

The means of therapy

The value of hormone therapy for this indication is of course well established. Both androgen and estrogen are known to inhibit the production and secretion of the lactogenic hormone by the anterior pituitary. As estrogen levels decline sharply at parturition, lactogenesis is established. When androgen and estrogen are administered to the patient before the release of the lactogenic hormone lactation and breast engorgement are usually prevented.

The time of therapy

The time of administration of this combined medication is crucial; it must be given early enough to suppress the pituitary prolactin and last long enough to permit physiologic readjustment during the puerperium. Excellent results are most often seen when therapy is administered before the onset of the second stage of labor.

However, factors other than effectiveness must also be considered. The agent selected should not interfere in any way with parturition, subsequent uterine involution and the restoration of normal ovarian cyclic function. Furthermore, it should not cause rebound breast engorgement or other manifestations of hormonal imbalance.

A balanced formulation

Providing single-dose therapy for the prevention of lactation and breast engorgement, Deladumone OB is a potent androgen-estrogen combination with a prolonged action. The optimal balance of androgenic and estrogenic hormones achieved in this preparation minimizes the disadvantages inherent in single hormone therapy, such as rebound breast engorgement. Involution of the uterus and resumption of menstrual cycles are not affected.

As reported in a recent published study (Roser, D. M.: Obstet. & Gynec. *27*:73, 1966), Deladumone OB provided good suppression of breast engorgement in 95.3% and suppression of lactation in 81.1% of 86 obstetrical patients. These results are in general agreement with those of many earlier investigations; in several studies this injectable androgen-estrogen combination proved to be superior to oral medication.

Dosage:

As a single injection of 2 cc. before the onset of the second stage of labor.

Contraindications:

Established or suspected mammary cancer or genital malignancy.

Precautions and Side Effects:

Certain patients may be unusually responsive to either estrogenic or androgenic therapy. In such individuals virilization, uterine bleeding or mastodynia may occur.

Supply:

Deladumone OB, providing 180 mg. testosterone enanthate and 8 mg. estradiol valerate per cc., is available in 2 cc. Unimatic® disposable syringes and in 2 cc. vials. Both preparations are dissolved in sesame oil, with 2% benzyl alcohol as a preservative. *Before use, consult product literature for full prescribing information.*

Deladumone® OB

Squibb Testosterone Enanthate (180 mg./cc.) and Estradiol Valerate (8 mg./cc.)

Single-dose injection for lactation inhibition

SQUIBB *'The Priceless Ingredient' of every product is the honor and integrity of its maker.*

nary artery disease. As yet, the causes and course of development of atheroma and its relation to coronary heart disease in man are imperfectly known. Disorders of fat transport or metabolism or both certainly participate, but are not the only factors. Heredity is involved in individual susceptibility. Disorders of blood flow and blood clotting are implicated in atheroma formation in addition to contributing to the fatal complications of the disease.

"EVIDENCE TO SUPPORT the concept that increased plasma concentrations of cholesterol are atherogenic is considerable but not conclusive . . . . Many, but not all, population studies indicate that diets high in fat, among other nutrients, are correlated with higher concentrations of plasma cholesterol and with increased prevalence of cardiovascular disease. However, proof of a causal relationship is lacking. In the majority of the adult population the concentration of plasma cholesterol can usually be reduced by increase in the quantity of polyunsaturated fat in the diet at the expense of saturated fat. That this degree of reduction in plasma cholesterol is beneficial is still uncertain . . . .

". . . IN SPITE of the large amount of information accumulated in recent years about atherosclerosis and its pathogenesis, many gaps in knowledge remain. Results of recent studies, while valuable and thought provoking, do not provide sufficient data for firm recommendations for radical dietary changes."

INCEPTION OF MEDICARE CAUSES NO HOSPITAL CROWDING

THE SOCIAL SECURITY Administration said that the 460,000 medicare patients in hospitals during the first month of the program's operation did not result in any overcrowding.

THERE WERE a few isolated instances of overcrowding, mostly in rural areas, but they already existed before medicare started July 1, the SSA said.

THE ELDERLY PATIENTS occupied from 30 to 35% of the beds in general hospitals, in comparison to about 25% before medicare. Federal officials had estimated a five percent increase.

INQUIRIES from intermediaries to SSA headquarters as to eligibility for Plan B medical benefits totalled 8,700 through July 22. A few spot checks showed assignments leading over direct billings by a small margin. But assignments normally would be filed sooner than direct billings. There still were about 200 hospitals in the south that had not been qualified as to civil rights requirements on racial integration. This situation left 132 counties that have hospitals with none qualified at the end of the month. By states, the counties were: Mississippi 31, Georgia 23, Louisiana (parishes) 19, Texas 12, Virginia 11, South Carolina 9, Alabama 8, Arkansas 6, Kentucky 6, North Carolina 3, Tennessee 2, Florida 2, and West Virginia 1. ◄

Doctor,

Here is the Abbott anorectic program designed to meet the individual needs of your overweight patients.

mood elevation

Abbott
Anorectic
Program

DESOXYN® Gradumet® (methamphetamine hydrochloride)

Smooth appetite control plus mood elevation.

The obese patient on a diet often has to battle depression as well as overweight. Desoxyn Gradumet helps the dieter in both battles by elevating the mood while it curbs the appetite. Thanks to the Gradumet, medication is smoothly released all-day from a single oral dose.

If she can't take plain amphetamine, put her on DESBUTAL® Gradumet

Calms anxieties; controls compulsive eating.

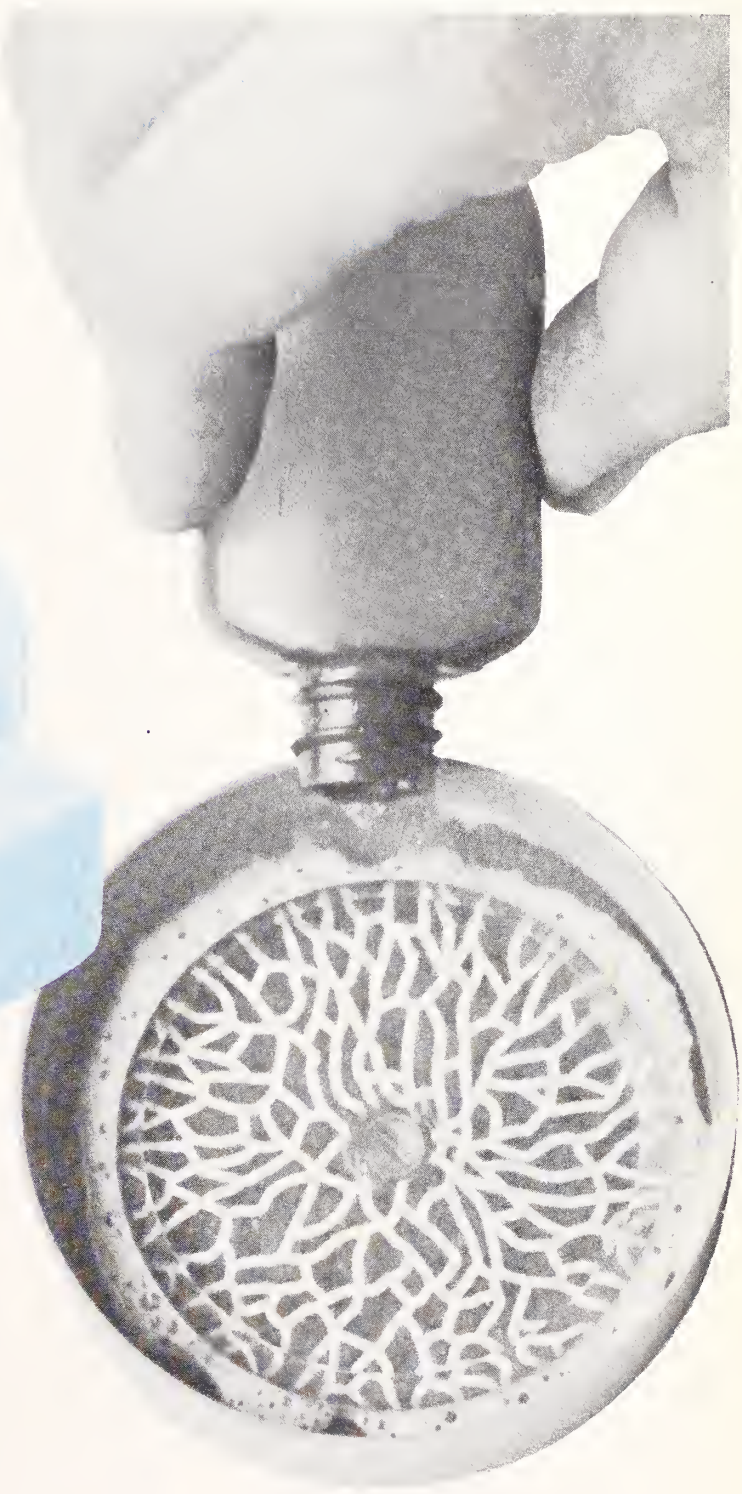
Desbutal Gradumet provides 2 drugs in 2 tablet sections, combined back to back to form a single tablet. One section contains Desoxyn to curb the appetite and lift the mood; the other contains Nembutal® (pentobarbital) to calm the patient and counteract any excessive stimulation.

Both drugs are released in an effective dosage ratio throughout the day.

controlled release

Abbott
Anorectic
Program

Not all long-release vehicles are the same. Here is why the Gradumet is different and what it means for your overweight patients.



The release action is purely physical and relies on only one factor common to every patient: gastrointestinal fluid. There is no dependence on enteric coatings, enzymes, motility, or an "ideal" ion concentration in the gastrointestinal tract.

Your patients get a measured amount of medication, moment by moment, throughout the day.

They are not subjected to ups and downs of drug release . . . or to erratic release from patient to patient . . . or to erratic release in the same patient from day to day.

That's why the Gradumet provides controlled-release as well as long release.

Perhaps you saw the Gradumet model demonstration which shows that the release is entirely physical. When fluid is added, the drug in the outer ends of the channels dissolves. As fluid penetrates deeper into the channels, there is a continuous release of medication. The rate of release is rigidly controlled by the size and number of channels.

choice of 5 strengths

Abbott
Anorectic
Program

DESOXYN Gradumet

Methamphetamine Hydrochloride in Long-Release Dose Form

5 mg. 10 mg. 15 mg.

DESBUTAL 10 Gradumet

10 mg. Methamphetamine Hydrochloride,
60 mg. Pentobarbital Sodium

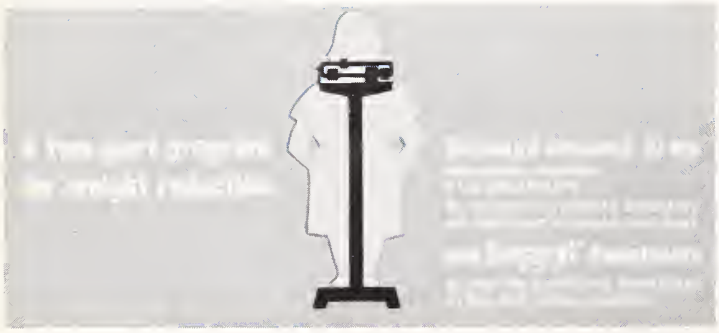
Front Side

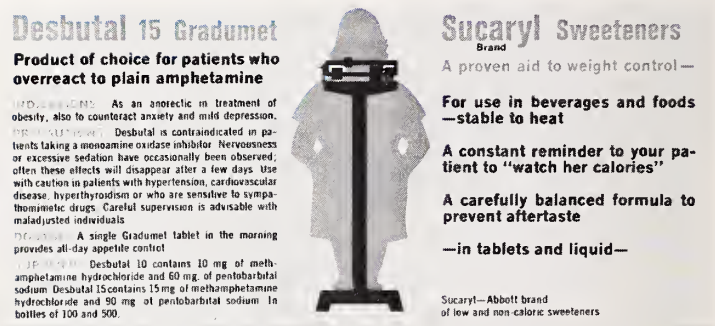
DESBUTAL 15 Gradumet

15 mg. Methamphetamine Hydrochloride,
90 mg. Pentobarbital Sodium

Front Side

samples available





Desbutal 15 Gradumet

Product of choice for patients who overreact to plain amphetamine

INDICATIONS: As an anorectic in treatment of obesity, also to counteract anxiety and mild depression.

CONTRAINDICATIONS: Desbutal is contraindicated in patients taking a monoamine oxidase inhibitor. Nervousness or excessive sedation have occasionally been observed; often these effects will disappear after a few days. Use with caution in patients with hypertension, cardiovascular disease, hyperthyroidism or who are sensitive to sympathomimetic drugs. Careful supervision is advisable with maladjusted individuals.

DOSAGE: A single Gradumet tablet in the morning provides all-day appetite control.

HOW SUPPLIED: Desbutal 10 contains 10 mg. of methamphetamine hydrochloride and 60 mg. of pentobarbital sodium. Desbutal 15 contains 15 mg. of methamphetamine hydrochloride and 90 mg. of pentobarbital sodium. In bottles of 100 and 500.

Sucaryl Sweeteners
Brand

A proven aid to weight control—

For use in beverages and foods —stable to heat

A constant reminder to your patient to "watch her calories"

A carefully balanced formula to prevent aftertaste

—in tablets and liquid—

Sucaryl—Abbott brand of low and non-caloric sweeteners

Press out tablets from this side. LOT NO 784 1331

For:

Directions:

Dr.

Each sample contains 6 tablets and a filled Sucaryl® Sweetener dispenser. For a supply, write Abbott Laboratories or ask your Abbott man.

economy

Patients, in many cases, save enough to get five weeks of medication for the price of four, compared to other leading long-release anorectics.

CONTRAINDICATION: Desoxyn and Desbutal are contraindicated in patients taking a monoamine oxidase inhibitor.

PRECAUTIONS: Use with caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs or ephedrine and its derivatives. Careful supervision is advisable with maladjusted individuals.

ABBOTT

Gradumet—long-release dose form, Abbott: U.S. Pat. No. 2,987,445.
Sucaryl—Abbott brand of low and non-caloric sweeteners.

601060

The human spine is not engineered for prolonged sitting at desks, pianos, typewriters and drafting boards. The stresses set up by the heavy, forward-tilted head and trunk, balanced precariously on an insufficient base, result in strain of the dorsal musculature, particularly at the low lumbar level.

The unusual muscle-relaxant and analgesic properties of 'Soma' make it especially useful in the treatment of low back sprains and strains. 'Soma' is widely prescribed ☐ **to relieve pain** ☐ **to relax muscles** ☐ **to restore mobility.**

Indications: 'Soma' is useful for management of muscle spasm, pain, and stiffness in a variety of inflammatory, traumatic, and degenerative musculoskeletal conditions. It also may act to normalize motor activity in certain neurologic disturbances.

Contraindications: Allergic or idiosyncratic reactions to carisoprodol.

Precautions: 'Soma', like other central nervous system depressants, should be used with caution in patients with known propensity for taking excessive quantities of drugs and in patients with known sensitivity to compounds of similar chemical structure, e.g., meprobamate.

Side Effects: The only side effect reported with any frequency is sleepiness, usually on higher than recommended doses. An occasional patient may not tolerate carisoprodol because of an individual reaction, such as a sensation of weakness. Other rarely observed reactions have included dizziness, ataxia, tremor, agitation, irritability, headache, increase in eosinophil count, flushing of face, and gastrointestinal symptoms.

One instance each of pancytopenia and leukopenia, occurring when carisoprodol was administered with other drugs, has been reported, as has an instance of fixed drug eruption with carisoprodol and subsequent cross reaction to meprobamate. Rare allergic reactions, usually mild, have included one case each of anaphylactoid reaction with mild shock and angioneurotic edema with respiratory difficulty, both reversed with appropriate therapy. In cases of allergic or hypersensitivity reactions, carisoprodol should be discontinued and appropriate therapy initiated. Suicidal attempts may produce coma and/or mild shock and respiratory depression.

Dosage: Usual adult dose is one 350 mg. tablet three times daily and at bedtime.

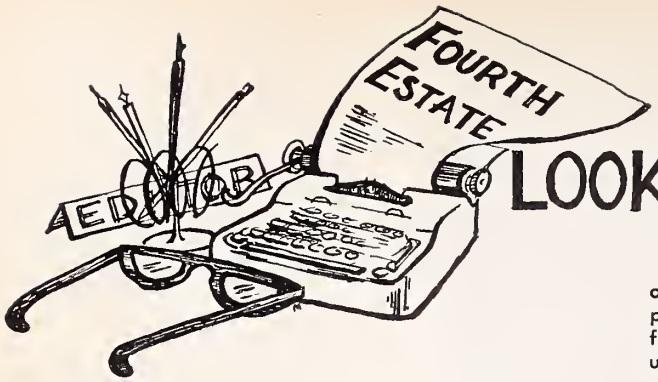
Supplied: Two Strengths: 350 mg. white tablets and 250 mg. orange, two-piece capsules.

Before prescribing, consult package circular.

for the relief of low back sprains and strains

SOMA®
(CARISOPRODOL)

Wallace Laboratories, Cranbury, N.J.
26S01J



LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

One School Or Two?

A legislative study committee's recommendation for establishment of a second publicly supported medical school in the state sets up a debate on the choice between this and an Indiana University plan for revision and expansion of the I.U. School of Medicine. This is good.

The plan indorsed by the Medical Education Study Committee of the General Assembly would require the development of a new campus and a new faculty. The committee chairman said this would take perhaps 10 years, to graduation of the first class. No cost estimates have been made.

The I.U. plan, drafted by a faculty committee, calls for a 25% expansion in the existing school. This also would take about 10 years. It would cost an estimated $6 million, in addition to another $6 million of construction which would be essential to the plan but which spokesmen said would have to be done in any case.

One basic feature of the I.U. plan has been indorsed by the legislative committee, which favors putting into effect whichever plan is adopted. This is a proposal for developing a substantial number of new openings for intern and resident training, by cooperative arrangements with hospitals throughout the state. The I.U. faculty committee said inadequacy of such openings is one of the bottlenecks in present preparation of physicians in Indiana.

Proponents of both plans are hopeful that action to start the ball rolling will be taken in the 1967 legislative session. In view of the time lag involved and the needs for physicians which already exist, this is a reasonable wish.

To help reach that objective, substantial debate on the merits of the two plans ought to be carried on before the session begins. The choice will require considerable study, calculation and consultation with experts. If all this is to be fitted into the myriad other demands of the 61 days, the groundwork will have to be done thoroughly. Otherwise the danger is that the project will be bogged down in controversy over the two ideas, and the session will wind up with nothing done about either one.

Each plan has some obvious advantages, already pointed out by the proponents. Each probably also has disadvantages. Every possible point on each side ought to be searched out and put into the balance before a decision is made.

There ought to be a decision, however. And it ought to be made in the 1967 session — *The Indianapolis Star*, July 29, 1966.

Sad

Down in Elwood, Ind., a small town northeast of Indianapolis in Madison County, best known as the home town of the late Wendell Willkie, the nine-member city medical society has decided not to participate in the federal Medicare program.

As a result, the elderly residents of Elwood who want to take advantage of Medicare will have to go out of town for doctors, or else will have to tackle the formidable red tape of direct Medicare reimbursement.

The Elwood doctors, without question or debate, have the right to do as they did and reject participation in Medicare. They see the program as an "opening wedge to socialized medicine," and perhaps they are even correct there, too.

But we find it sad to contemplate the elderly members of the Elwood community who find themselves without a choice of Medicare participation through a local doctor — all in the name of the doctors' right of choice.

Doctors who are enthusiastic about Medicare or its broader social implications are about as rare as kielbasa-haters on the South Bend West Side on Dyngus Day. Yet most medical men accept the fact, however reluctantly, that Medicare is now a fact of life, voted into existence by a freely elected Congress.

And so most doctors, like a majority in St. Joseph County, not only have chosen to go along with Medicare, but actively urge their patients to take advantage of the medical-free option incorporated in the program.

In Elwood, the doctors chose otherwise. We find the St. Joseph County way far more edifying. — *South Bend Tribune.*

The Doctors and Medicare

For better or worse, Medicare is officially in operation.

The hope, of course, is that it will be for the better, that it will both improve the health of the nation's elderly and grant them a new freedom — or at least a measure of freedom — from

the specter of disabling injury or illness that could wipe out their life's savings and make them a burden on their children.

It is more than a hope. It is the belief of millions of Americans, who express their wishes through their representatives in Congress.

Medicare will inevitably cause some strains and dislocations within the nation's medical facilities, which are not geared for any great upsurge of demands upon them.

These strains, if they develop, will require time, money and effort to overcome. But they will also serve to reveal weaknesses and deficiencies in our medical resources that ought to be remedied even if there were no Medicare.

The real, long-term success of the program rests in the hands of America's 300,000 doctors. They did not want it for the most part; they fought it, but now they have it and only they can make it work.

Let them heed the words of Dr. Charles L. Hudson, new president of the American Medical Association:

"We are not stepping off the brink into a bottomless pit of professional destruction and despair," he said in his inaugural address before the AMA's policy-making House of Delegates, meeting in Chicago.

For many physicians, that bottomless pit holds the fear that Medicare is but the first long step on a short road to the nemesis called "socialized medicine."

If this is so, and if it is something that should not be allowed to happen, then let them be reminded that the most effective lobby for socialized medicine, as it was for Medicare, is a hidebound medical community that says, "No, no, a thousand times no," rather than, "Wait, we have a better idea."

Rather than waste their "collective professional energy to belabor the past," said Dr. Hudson, doctors must become "receptive to new ideas and become the leaders in experimentation in the mechanism of medical practice."

For the simple truth is that if doctors do not lead, they will be led. — *Marion Leader-Tribune,* July 4, 1966.

Back Medical School In Our Area

This section of northern Indiana strongly merits selection as site for Indiana's proposed second medical school.

Our case was greatly enhanced, we believe, by action Tuesday of the State Legislative Advisory Committee to Study Medical Education.

The committee narrowed its choice to South Bend, Evansville and Muncie.

That eliminates consideration of Lake County and Terre Haute as possible second medical school sites. Also ruled out was the Indiana University proposal to expand the present I.U. Medical School at Indianapolis.

The committee is to meet at Indianapolis August 9 to decide which site to recommend.

Two main arguments for the South Bend site concern population trends and existing academic facilities.

The 23 northern Indiana counties are expected to have a population increase of 156% between 1940 and 1990, according to a report prepared by Sidney G. Tickton, vice president of the Academy for Educational Development.

His report is based on figures supplied by the U.S. Census Bureau, I.U. Bureau of Business Research, utility firm economists and officials of the State Department of Health.

The same report shows that the central Indiana counties including Delaware (Muncie) are due for a 104% population growth in the same time, while southern Indiana counties are calculated to have a 34% growth.

Too , a new medical school at South Bend, adjacent to Notre Dame University, would benefit from its association with the already strong graduate program at Notre Dame. I.U., with its fast-growing South Bend campus, also is outstanding in graduate work.

Evansville, with its Evansville College and an extension of Indiana State University, has nothing to compare with South Bend for graduate academic facilities.

The same is true of Muncie, where Ball State University still primarily is a teacher's training institution and is just at the start of a graduate program.

Surely a second medical school should be built where there is now and henceforth, the greatest demand for more doctors. Surely such a school should be built where other existing academic facilities are best.

Muncie area people can readily be served by the existing I.U. School of Medicine, 60 miles away.

On a priority basis, northern Indiana has the best claim to a new Indiana medical school (and we hope Lake County, which has lost its own bid, now will support the South Bend site which would be comparatively close).

Southern Indiana logically would qualify for a third Indiana medical school, when such might be deemed necessary, which would give the state three such institutions well spaced, north, central and south.

But let's put the second school where it so clearly belongs — in northern Indiana. — *The Elkhart Truth,* July 28, 1966.

The Bill For Medicaid

Indiana taxpayers have received an estimate of their forthcoming bill for the "Medicaid" sleeper in the Medicare act. For the first year it's expected to be $30 million, with $14.3 million coming from state tax revenues and $15.3 million from Federal tax funds.

Medicaid is a Pandora's box which passed under the label of Title 19 in the Medicare bill. Very little attention was paid to it at the time, and it carried a Federal cost estimate of $238 million. It provides for new state programs to pay medical and dental bills for persons on welfare and others who "can't afford" to pay their own bills. The definition of who can't afford it was left to the states.

The Indiana proposal, as drafted by a legislative advisory committee headed

Continued on page 1006.

When thiazide or reserpine alone won't keep

Establish and maintain early, more decisive control of blood pressure

DIUTENSEN®-R

Cryptenamine 1.0 mg.* Methyclothiazide 2.5 mg. Reserpine 0.1 mg.

When blood pressure won't stay down despite initial therapy—when complaints of headache, fatigue or dizziness are often voiced—it may be time for a change to DIUTENSEN-R.

DIUTENSEN-R is thiazide and reserpine *plus cryptenamine*—a rational, comprehensive therapy to help establish and maintain early, more decisive control of blood pressure.

The cryptenamine in DIUTENSEN-R helps improve normal vasodilating reflexes while the thiazide and reserpine components maintain vasorelaxant, sedative, and saluretic benefits. Cryptenamine lowers pressoreceptor reflex thresholds (which may be abnormally high in hypertension)—"resets" pressoreceptors to function at more nearly normotensive levels.

Early, more decisive control with DIUTENSEN-R helps secure continuing benefits — may reduce or even obviate the need for poorly tolerated drugs later in therapy.

"...quite apart from the problem of vascular damage, there arises a possibility of virtual 'cure' or remission of hypertension when treatment is early, i.e., before too many other secondary pressor systems have entered into the disequilibrium of pressor control, and when it is adequately suppressive."

Corcoran, A. C.: The choice of drugs in the treatment of hypertension. In: Drugs of Choice 1966-67, W. Modell, Ed., St. Louis, C. V. Mosby Company, 1966, p. 417.

Indications: DIUTENSEN-R may be employed in all grades of essential hypertension. **Dosages:** Usual dose is 1 tablet twice daily, at morning and evening meals. However, adjustment of dosage to suit individual circumstances may be required. Please refer to package insert for full particulars. **Side effects and precautions:** The side effects observed with patients on DIUTENSEN-R have been of a mild and nonlimiting nature. These include occasional urinary frequency, nocturia, nasal congestion, muscle cramps, skin rash, joint pains due to gout symptoms and nausea and dizziness which have been reported for the individual components. Most of these symptoms disappear while the drug is continued at the same or lower dosage level. The concomitant use of digitalis and DIUTENSEN-R may increase the possibility of digitalis-like intoxication. If there is evidence of myocardial irritability (extrasystoles, bigeminy or AV block), dosage of DIUTENSEN-R should be reduced or discontinued. Nocturia in patients with marginal cardiac status and salt and fluid retention can be effectively controlled by limiting the time of administration to early afternoon. DIUTENSEN-R should not be used in patients with a known intolerance to reserpine. Package inserts furnish a complete summary of recommended cautions related to each of the ingredients of DIUTENSEN-R.

*As tannate salts equivalent to 130 Carotid Sinus Reflex Units.

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by Senator James M. Kirtley of Crawfordsville, is relatively modest. It fixes income eligibility of $1,200 a year or less for a single person, $2,400 or less, plus $600 for each child, for a married couple. Some limited exceptions are provided for special situations.

Some states have already adopted programs, and received Federal approval for them, on a far more generous basis. By the time the Department of Health, Education and Welfare had approved the programs of seven states and Puerto Rico, the indicated first year Federal cost already was $170 million above the $238 million estimate. Highest in this list were California at $180 million, Pennsylvania at $100 million, Illinois at $40 million and Minnesota at $30 million.

Still to come was a New York program which started out at an estimated $217 million tab for the Federal Treasury. The New York legislature has had some second thoughts, however, and the program has been trimmed back somewhat.

Officials of HEW now foresee that if all the states participate the first year's Federal bill might be a billion or more. And this could be just the beginning.

The prospect has caused some nervousness in Congress. The House Ways and Means Committee has been holding closed hearings which might result in a proposal for an amendment to write some eligibility rules into Title 19. By all means this should be done.

Perhaps some Congress some day will learn not to write blank checks for Federal spending programs. We earnestly hope so. — *The Indianapolis Star*, July 20, 1966.

No Solution

It is gratifying to see that the Committee to Study Medical Education in Indiana recognizes there's a doctor shortage in the state; and there's also some satisfaction in seeing they've recommended an expanded intern system for the state.

The committee also has recommended another medical school for the state. Now this is nice.

There are several cities in Indiana fighting for the prestige that attaches to a medical school, so the committee is certain to make at least one of these communities happy when it suggests a location. Of course, it'll make all the others mad.

Another thing: The school can be built. The state has enough money to get the bricks laid, to buy equipment, and to set up a faculty lounge. But where will it get the faculty? The present medical school at Indianapolis has plenty of problems along this line, and the new medical school will not come with built-in teachers.

Furthermore, it won't solve the problem. The I.U. School of Medicine already graduates sufficient medics to serve the state. The trouble is that they don't stay here after they graduate. The Hoosier internship program is so weak that new doctors are attracted elsewhere, and elsewhere is where they practice.

The money spent on the new school would better be applied to upgrading present teaching hospitals and improving interns' salaries.

And if the rest of the people in Indiana would keep their home state as attractive as God made it, perhaps these young doctors would never want to leave. — *Martinsville Reporter*, July 27, 1966.

If You Must Drive . . .

A pediatrician and an orthopedist, deeply involved in efforts to lessen the automotive death and injury toll, chose the American Medical Association's annual convention as the forum for giving would-be July Fourth weekend travelers some rather drastic advice. What they said, in essence, was: "Stay out of cars."

There was more to it than that. Dr. Seymour Charles of Newark, N. J., and Dr. John States of Rochester, N. Y., each of whom is president of a medical group concerned with different aspects of auto safety, urged as an alternative to weekend auto travel the use of buses, trains and planes.

That advice may be excellent, but the chances are that few bent on holiday journeying will change their plans because of it. Recognizing this, the doctors offered suggestions for minimizing the dangers of going by car.

The points they made are worth reiterating on the verge of one of the year's heaviest traffic week-ends. Perhaps because Dr. Charles is a pediatrician, they had a special word about children: Don't let them clamber about in the car, lest they become missiles — deadly to themselves and other passengers alike — in a collision. By the same token, they urged keeping loose objects off the rear shelf.

Lock the doors, they said. And, since "Detroit provides grossly inadequate door latches," provide shoulder harnesses in front and seatbelts in the rear. To cut the danger of blowouts, they recommended higher tire pressures. They also urged such old standbys as staying sober and avoiding peak traffic periods. It's all sound advice. Taking these and other precautions that come to mind will not guarantee a safe trip. It will improve the odds for driver and passengers. — *Terre Haute Star*, July 3, 1966. ◄

An Unforeseen Collision

"Everybody is willing to turn the machine on, but nobody is willing to turn the machine off. The doctor needs

some help in making this decision."

These words, spoken during a panel discussion between physicians and clergymen who are members of the American Medical Association's Committee on Medicine and Religion, accurately sum up the medical-moral quandry that is facing more and more doctors today.

The "machine" may simply be new drugs which keep the body going long after the spirit has surrendered; or it may be an actual one — a mechanical device like a respirator or pump that takes over the functions of the lungs or kidneys. One day it will be the artificial heart which medical science is on the threshold of perfecting.

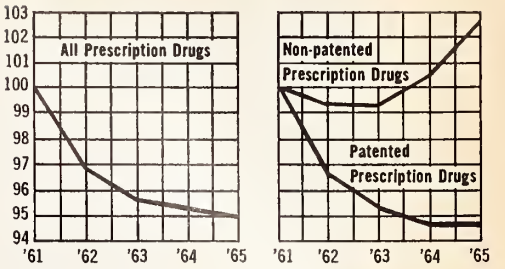
Headlines recently told of the first implantation of a partial artificial heart in a patient by famed surgeon Michael DeBakey. It is significant that DeBakey himself raised questions about the profound implications of this development.

"Should this lifesaving device be made available to every patient," he asked, "even the hopeless victim of stroke, cancer or senility? . . . And who decides to terminate the power flow in such cases?"

Physicians, of course, have always been faced with agonizing decisions concerning the life or death of their patients. Today, however, the choice is frequently not that between restored, productive life on the one hand and unfortunate death on the other, but between pain-releasing death and a prolonged existence in a vegetative limbo measured only by a series of pulse beats on an oscilloscope.

In such cases, the question ceases to be a purely medical one and begins to take on theological and legal aspects, transforming itself into something which neither physicians or theologians or lawyers are yet prepared to cope with. — *Terre Haute Star*, May 27, 1966. ◄

Producers' Prescription Drug Prices Decline



Source: U. S. Bureau of Labor Statistics

Source: Pharmaceutical Manufacturers Assn.

While prices in general continue to rise, drug price levels have declined significantly. The wholesale price level of "all prescription drugs" has declined five percent since 1961. Even more dramatic is the downward trend of **patented** prescription drugs. These have declined 5.3 percent during the same period compared with an **increase** of 2.5 percent for those which are not patented. — Courtesy of the Pharmaceutical Manufacturers Association.

has a diet drink

named

Its flavor is lemon-lime

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SEVEN-UP BOTTLING COMPANY, INC.

good reason to select Ilosone®

Erythromycin Estolate

for bacterial infections

two to four times the therapeutic activity of other erythromycins

CONTRAINDICATIONS: Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with preexisting liver disease or dysfunction.

SIDE-EFFECTS: Even though Ilosone is the most active oral form of erythromycin, the incidence of side-effects is low. Infrequent cases of drug idiosyncrasy, manifested by a form of intrahepatic cholestatic jaundice, have been reported. There have been no known fatal or definite residual effects. Gastro-intestinal disturbances not associated with hepatic effects are observed in a small proportion of patients as a result of a local stimulating action of Ilosone on the alimentary tract. Although allergic manifestations are uncommon with the use of erythromycin, there have been occasional reports of urticaria, skin eruptions, and, on rare occasions, anaphylaxis.

DOSAGE: *Children under 25 pounds*—5 mg. per pound of body weight every six hours. *Children 25 to 50 pounds*—125 mg. every six hours. *Adults and children over 50 pounds*—250 mg. every six hours. For severe infections, these dosages may be doubled.

Available in Pulvules®, suspension, drops, and chewable tablets. Ilosone Chewable tablets should be chewed or crushed and swallowed with water.

Additional information available to physicians upon request.
Eli Lilly and Company, Indianapolis, Indiana 46206.

Lilly

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The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Supervised by The COUNCIL

Volume 59 — September 1966 — Number 9

Diffuse Scalp Hairfall in Women*

T. D. ARLOOK, M.D.
Elkhart

THE problem of diffuse hairfall of the scalp of women appears to be on the increase. One wonders if this is indeed a modern day problem or has it always been with us?

Sulzberger, Witten and Kopf[1] wrote to 170 experienced dermatologists asking if they felt there was an increase in diffuse hairfall among women. One hundred and six answered, of which 53% felt there had been an increase; 30% reported no increase and 15% were not sure.

Perhaps more women are seeking medical attention at the present time than in the past and, therefore, dermatologists are noting some increase. The question cannot be answered definitely at this time.

Seldom do women become entirely bald, but a noticeable thinning or alopecia of the scalp is indeed of prime concern to them and it behooves the physician to consider this a major condition insofar as its psychological aspects are concerned. If medical aid is not possible, a sympathetic explanation is indicated. The patient by all means deserves a clear explanation of what pathologic process is present in the scalp and what to expect in the future, but this must be done as an "art of medicine," bearing in mind the psychiatric implications.

Since we are going to deal in this article with the biological or physiological process of anagen, catagen and telogen of the hair growth cycle, an explanation of this phenomenon is in order.

Kligman[2] writes of three phases of the hair growth cycle. Briefly stated, anagen refers to that stage of the hair growth cycle in which the hair follicle is active and the shaft of hair is in growth. Catagen is the brief intermediate stage of the hair growth cycle leading to the terminal stage of telogen. Orentreich[3] would like to call catagen by the term "metagen" since he feels it is more descriptive of the process. The telogen phase of hair growth cycle is the terminal aspect in which the hair shaft falls out and the papilla rests.

Etiology

Common baldness in the female has three factors.[4] They are: (1) proper age; (2) androgen stimulation; (3) genetic pattern of individual.

Age: Evidence of diffuse hairfall doesn't manifest itself before the third and fourth decade, a period obviously later than that of the male. Normal baldness occurs in the female about the age of 70 to 80.

Androgen stimulation: Hairfall doesn't become noticeable until six to nine months after androgen stimulation. This, according to Hamilton,[5] is an irreversible process. Excessive internal androgen stimulation has been regularly noted in patients with common female baldness. Other dermatologic conditions of the scalp such as seborrhea did not seem to play an important role in this type of alopecia.

In a paper given by Papa and Kligman[6,6A] concerning experiments with one percent testosterone propionate in hydrophylic ointment, there appeared to be some limited regrowth of scalp hair after several months of daily application. These patients were in an institution and therefore under strict control in treatment of male and female patterned baldness. This experiment would indicate that not all hair papillae, even after years of nongrowth of hair, are dead, but only in a dormant state.

Foss[7] in 1939 used an ointment containing 25 mg. testosterone propionate per gram, dispensed in collapsible tubes, with directions to rub the ointment well into the scalp.

Binazzi and Wierdis[8] attempted a clinical and metabolic study of Sabouraud's female seborrheic alopecia and of Juster's female alopecia of the vertex. They found a hypophyso-ovario-adrenal hormonal disorder of variable degree but substantially it was the same in the two classes. The reduction of

*Presented at the eighth annual meeting of the Noah Worcester Dermatological Society, Scottsdale, Ariz., March 28-April 3, 1965.

estrogenic activity represented apparently the primary point of this dyshormonal condition.

Satisfactory results were obtained by small doses of cortisone derivatives and followed or preceded by administration of diencephalic lipid extracts.

Based on their personal data, they proposed the name "hypoestrogenic alopecia" for this type of disease.

Genetics: Women with a heredity of premature baldness in their family are prone to develop premature alopecia. An excess of androgen in a woman with a family background of no alopecia is not apt to be affected.

Mother-daughter pairs of alopecia were common in a series of cases studied. In a large study of men and women with premature baldness, Snyder and Yingling[9] found that female-male ratio for common baldness was 7.8 to 43.0. They concluded that the hereditary transmission of common baldness is due to an autosomal gene of variable expressivity that required sufficient androgens and age for its appearance.

Leider and Berger[10] list additional factors for feminine hairfall such as brush hair curlers causing tension on scalp; hair styles using braids and pony tails which interfere with scalp circulation. This may cause temporary or permanent alopecia depending on the degree of tension on the scalp and the period of time involved. In other words, there is a breakup of the hair shafts and injury to the hair bulbs. The pattern of baldness is determined by where traction exerts itself on the scalp — usually the frontal or temporal areas. Variations of alopecia are noted in Negro children with their separate braiding. In our present-day society, the excessive use of chemicals for waving, rollers in setting, dyeing the hair, "teasing" and "ratting" are traumatic to the hair.

Another possible cause of diffuse hair loss of both sexes could be our chemical age. We are exposed daily to various foods with their additives, drugs, cancer cytotoxic drugs, thallium compounds, polluted air and excess of Vitamin A.

Various febrile diseases and syphilis can also cause diffuse hair loss.

Schiff and Kern[11] relate that in a study of 96 patients with post-partum alopecia, only a few gave a family history of hair loss, suggesting that heredity is not a factor. In 88.8% of the cases, the hair loss began eight to 16 weeks after delivery. The anterior scalp was involved in 59.1%. In 20.4%, it was a diffuse alopecia over the entire scalp and in 11.2%, the frontal region alone manifested the condition.

Seborrhea is not a factor of significance. It requires four to six months for the scalp to regrow in 66.6% of the cases. With only two exceptions, there was complete regrowth and in these, other factors were involved.

Lynfield[12] and Kligman have established the fact that post-partum alopecia is probably the result of acceleration of conversion of the anagen phase of the hair to the telogen terminal phase with shedding, the latter being referred to as post-partum telogen effluvium. Lynfield thinks these alterations in the hair cycle due probably to the changed endocrine balance.

Behrman[13] surmised that post-partum alopecia may be the result of an estrogen deficiency state resulting from an inhibiting effect on the gonadotropic activities of the pituitary gland by the high steroid levels occurring during pregnancy. Three women with multiple pregnancies who failed to develop alopecia when a new pregnancy occurred early in the post-partum period pointed to a hormonal imbalance. Explanation of this phenomenon to women in this state would do a great deal to allay their apprehension. Most women can be convinced that their hair will gradually regrow.

Hair loss from the anticoagulants heparin and coumarin can be prolonged because the drug converts hair follicles from the anagen to the telogen phase. Likewise, alkylating agents and mitotic inhibitors such as aminopterin, methotrexate, colchicine and the defunct anti-cholesterol compound drug Triparanol all can cause hair loss, not only of the scalp but other areas of the body. Anti-cancer drugs seem to interfere with the mitotic activity in growing hair, thereby altering the production of keratinized cells without affecting the hair cycle. Hair growth resumes after the cessation of anti-cancer therapy.[2,14]

A Spanish dermatologist, Argonilla Fernandez,[15] discusses alopecia disseminata due to iron deficiency anemia and finds it confined exclusively to the female sex. It was corrected in three weeks with administration of an iron preparation.

Some workers feel that merely applying and removing scalp medication excessively is severe enough to trigger traumatic alopecia.[16]

In 1956, Grover[17] reported diffuse shedding of hair in six female subjects using a selenium sulfide suspension shampoo for varying periods of time. In all cases, hair loss ceased on discontinuing the shampoo. In 1960, Archer and Luell[17] applied the hair plucking technic of Van Scott et al. in the investigation of hair growth in four subjects. After shampooing with 2.5% selenium sulfide suspension, they claimed an increase in percentage of dysplastic hair in two of four subjects.

However, Orentreich and Berger,[18] by studying the anagen-telogen ratio, could not find any significant damaging effect of selenium disulfide suspension on the hair growth or noticeable effect on the percentage ratio of growing and resting hair after a single shampoo or prolonged shampoos.

Emotional shock or disturbances certainly may be the basis for diffuse hair fall.

Pathology

The normal hair follicle may be conceived as a specialized invagination of the skin lined with epithelial cells; at its base it houses the hair matrix whose keratinizing cells form the dead hair shaft. A supporting framework of connective tissue is wrapped around the follicle. The connective tissue sheath,

with its rich vascular plexus, is the true seat of the disease process.

In common baldness[4] there is a non-inflammatory degeneration of the connective tissue sheath: this begins at its base and progresses upward. The ultimate result is a sclerotic obliteration — total loss of the hair-forming portion of the pilosebaceous apparatus. Even late in the disorder, the sebaceous glands and sweat glands appear normal. As the follicle recedes, it leaves behind a strand of sclerosed connective tissue which formerly enveloped it, a shrinking follicle substituted by a fibrotic strand, often hyalinized cord, which trails into nothing below.

Eventually the fibrotic connective tissue cord is obliterated being totally replaced by fat and connective tissue.

Diagnosis

In general, female common diffuse baldness resembles that of the male with the exception that the latter is more complete with an ensuing shiny, denuded pate of the involved areas. The female shows a markedly thinned pate but not complete baldness.

The alopecia never begins nor manifests itself as a distinctly circumscribed oval area over the posterior crown. The frontal receding area is not visually evident clinically because there is no true baldness. The thinner, shorter not well pigmented club hairs which remain are fewer in number. As stated, there may be a complete frontal baldness but this is not common.

A more specialized method to determine the status of hairfall was done by Orentreich and Berger[3] in which about 125 hairs of the scalp were rapidly plucked with a needle holder with rubber tips. The distal ends of the hairs were cut off with scissors and the root portion was stained and placed in water in a petri dish for easier counting. The telogen phase of hair has no sheath and an anagen-telogen ratio was established to determine state of hair loss.

Therapeutic Aspect

It is understandable that the therapeutic approach rests upon the etiologic factors of female baldness. A careful history of any medication taken; genetic background as to scalp retention of hair in the family blood relationship; any endocrinopathy, obvious or inferred; febrile illnesses, syphilis, anemia, post-partum status; mechanical trauma such as traction from braiding, brush hair curlers, etc., and psychogenic factors should be gone into with the patient. Then, too, a physical examination is in order, with examination of thyroid, evidence of adrenal tumor and ovarian pathology. Wegner and Humplik[19] proposed in 1959 a method of improvement of scalp circulation by surgical relaxation of any tight aponeurosis of the scalp.

Orentreich,[20] as a matter of interest, has a method of transplantation of hair from the hairy occipital to the frontal bald and other bald areas of the scalp by a punch which encompasses five to 15 hairs. Each punch of scalp removed is placed into a previously prepared, correlated, punched-out area and sutured.

This method is quite practicable for a male where there is a complete absence of hair at the bald part but not too good cosmetically for the female in which baldness is not complete and in which thinned hair remains.

In cases where cancer cytotoxic drugs are being given, hair loss is temporary and will regrow on cessation of medication. Anticoagulants will cause hair loss more prolonged because the hair follicle is thrown into telogen.

Women with a genetic history of premature baldness in their family can only be psychologically prepared for this gradually permanent hair loss. Fortunately many types of wigs are now on the market to suit any woman's taste in hair coiffure.

In the endocrinopathies-thyroid dyscrasia can usually be corrected and virilizing adrenal tumors often can be successfully operated upon.

Most febrile illnesses as well as secondary syphilis cause only temporary hair loss and the condition can be treated.

Post-partum hair loss of the mother occurs about eight to 16 weeks after delivery of the infant and regrows in four to six months. Reassurance is the answer to the worried mother.

Removal of traction caused by braids and hair curlers in most instances will allow hair to regrow by improvement of the scalp circulation. Replacement of nylon hair brushes with a natural bristle brush will remove scalp and hair trauma.

Treatment of iron deficiency anemia will aid quickly in regrowth of hair caused from this factor.

When psychogenic stress is the etiologic reason, careful appropriate psychiatric advice is in order.

Summary

The problem of diffuse hairfall of the scalp of women appears to be with us. Whether there are a greater number of women that now suffer from this condition than previously is not definitely answered.

Study of this condition is enhanced by means of evaluation of hair cycle phases — anagen, catagen and telogen. Briefly, the hair cycle is divided into three parts: (1) anagen, or the growing phase; (2) catagen, or intermediate phase; and (3) telogen in which the hair is shed and the papilla rests.

The prime etiological factors appear to be: 1. Age: The hairfall seems to start in the third and fourth decade and is gradual. The male hairfall, therefore, starts much earlier than the female. 2. Androgen stimulation: Hairfall doesn't become noticeable until six to nine months after androgen stimulation and in this case, is an irreversible process. However, in other etiological female diffuse baldness, it is not an irreversible condition. 3. Genetics: Women with an heredity of premature baldness in their family are prone to develop premature alopecia whereas those with a non-alopecia background are not apt to suffer from this condition.

Other factors listed in cause of dif-

fuse hairfall are: Mechanical: Which includes brush hair curlers, braiding of hair, pony tails with ensuing inhibition of scalp circulation, nylon brushes causing trauma to scalp and hair, trichotillomania if enough of the scalp is involved. Chemical: Which includes excessive use of dyes, wave set solution, and hair sprays. Drugs: Including anticoagulants such as heparin and coumarin, antimetabolites, alkylating agents and excess Vitamin A intake. *Various febrile diseases* and *syphilis, iron deficiency anemia, post-partum alopecia* and emotional shock or disturbances.

Pathology of the hair follicle with its sheath is discussed.

Diagnosis of female baldness takes into consideration the age, endocrine status and genetic background of the individual and the area of scalp involved. It is noted that the baldness is non-cicatricial and involves first the frontal area and gradually extends to vertex and may include some of parietal areas. An anagen-telogen ratio can determine the state of hair loss. The other factors of mechanical trauma, chemical, febrile history, etc. should be taken into consideration.

Therapeutically, one has to deal with the etiology of the hair loss. If the genetic background of the individual is at fault, not much can be done to regrow hair. If the hair loss etiology is understood to be caused from a febrile disease, syphilis, post-partum status, mechanical, chemical or psychologic stress, then much can be done in reassurance and treatment of the patient.

BIBLIOGRAPHY

1. Sulzberger, M., Witten, V., Kopf, Alfred W.: Diffuse Alopecia in Women, *Arch. Derm.* 81:556-560, 1960.
2. Kligman, A. M.: Pathogenic Dynamics of Human Hair Loss (Telogen Effluvium), *Arch. Derm.* 83:175, Feb., 1961.
3. Orentreich, Norman: "Significance of Hair Cycle for Dermatologists." Lecture at Advanced Seminars in Dermatology, University of California, California Alumni Association Meeting, Tahoe Alumni Center, Lake Tahoe, California, July 5, 1963.
4. Maguire, Jr., Henry C., Kligman, Albert: Common Baldness in Women, *Geriatrics* 18:329-334, April, 1963.
5. Hamilton, J. B.: Effect of Castration in Adolescents and Young Adults Upon Further Changes in the Proportions of Bare and Hair Scalp, *J. Clin. Endocrinol.* 20:1318-1390, 1960.
6. Papa, Christopher, Kligman, Albert: Stimulation of Hair Growth by Topical Application of Androgens in Patterned Male and Female Baldness. Paper read at Amer. Acad. Derm. Meeting, Dec. 10, 1964.

6A. Papa, C. M., Kligman, A. M.: Stimulation of Hair Growth by Topical Application of Androgens, *JAMA* 191:7, 521-525, Feb. 15, 1965.

7. Foss, C. L.: Percutaneous Absorption of Testis Hormone, *Lancet* 2: 1284, 1939.
8. Binazzi, M., Wierdis, T.: Excerpts *Med. Derm. and Venerol.* 15:1982, 1963. Clin. Derm. et Clin. Obstet., University de Perous Ann. Derm. Syph., Paris, 1962. 8 9/4, (382-386.)
9. Snyder, L. H., Yingling, H. C.: Studies in Human Inheritance; Application of Gene Frequency Method of Analysis to Sex Influenced Factors with Special Reference to Baldness. *Human Biol.* 7:608-15, 1935.
10. Leider, Morris, Berger, Robert: Diffuse Loss of Scalp Hair in Women, *Skin* 1:10, Nov., 1962.
11. Schiff, M. D., Bencel, L., Kern, Arthur B.: Study of Post-Partum Alopecia, *Arch. Derm.* 87:609-611, 1963.
12. Lynfield, Y.: Effect of Pregnancy on the Human Hair Cycle, *J. Invest. Derm.* 35:323, Dec., 1960.
13. Behrman, H. T.: *The Scalp in Health and Disease*, C. V. Mosby Co., St. Louis, p. 101, 1952.
14. Baer, Rudolph: "Newer Concepts of Cutaneous Drug Eruptions — Symposium of Cutaneous Manifestations of Systemic Disease." Published by Division of Scientific Publications, Medical Society of State of N. Y. Presented at N. Y. State Society of Internal Medicine, March 2, 1963.
15. Fernandez, Argonilla L.: *Octa. Derma-Sifil,* Madrid, 1963, 5 4/7 (407-408). Diffuse Alopecia Due to Iron Deficiency Anemia. Excerpt. *Med. Dermat. and Venerol.* 3670.
16. *Diseases of the Skin*, Sutton and Sutton, 10th Edition; Noncicatricial Alopecia, p. 1400.
17. *Drug and Cosmetic Industry Magazine*, Vol. 95, No. 2; p. 278, August, 1964.
18. Orentreich, N., Berger, Robert: Selenium Disulfide Shampoo — Its Influence on Hair Growth and Follicular Cycle, *Arch. Derm.* 90:76, 1964.
19. Wegner, J., Humplik, H.: The Conference of Biology Clinic; Therapy of Hair Disease Held at Lausanne, Switzerland, May 25, 1959.
20. Orentreich, N.: Report Delivered at American Academy Dermatology, Chicago, Dec., 1962. ◄

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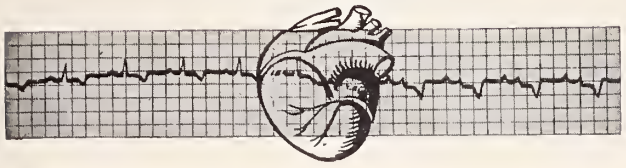
Electrocardiogram of the month



Presented as a regular feature of The JOURNAL, Electrocardiogram of the Month is a series of short talks on cardiovascular diagnosis and treatment, edited by the staff of the Krannert Heart Research Institute, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis.

Paroxysmal Atrial Tachycardia (PAT) with Block (8)

Ventricular Premature Systoles (VPS) and Nonparoxysmal AV Nodal Tachycardia (NT)

CHARLES FISCH, M.D.
Indianapolis

BECAUSE about 50% of PAT with block is due to digitalis toxicity, it is not surprising that this arrhythmia is often accompanied by other digitalis-induced disturbances of rhythm. The case presented in this report is a very complex arrhythmia due to digitalis which includes PAT with block, VPS and NT with 1:1 response and 2:1 exit block (Figure 1).

The top row demonstrates the atrial rhythm at a rate of 214 per minute. There are two types of QRS, smaller in amplitude and of normal duration, and these originate in the AV node. The rate of discharge of the focus responsible for these complexes when allowed to excite the ventricle is 88. This rate is established by two consecutive nodal beats (sixth and seventh) seen in the middle of the top row. The larger, negative QRS complexes are VPS. The diagnosis of nonparoxysmal nodal tachycardia is made on the basis of lack of any temporal relationship (fixed P-R) of the P waves to the QRS complexes indicating that the P waves are not responsible for the QRS complexes. The latter originate in an independent ectopic focus, in this case because of normal configuration, in the AV node.

In the second row (AVR), the P waves of the PAT are inverted and their rate is the same. The P waves are best seen toward the end of the strip but can be seen to be superimposed on the complexes of the remainder of the tracing. Again the P waves have no fixed relationship to the QRS indicating that the two are independent, the P wave originating in the atrium and QRS in the AV node. The rate of the nodal discharge in AVR and AVL is exactly twice that seen in AVF, namely 176. The latter is the true nodal discharge rate and the rate recorded in AVF represents a 2:1 exit block from the AV node.

As was pointed out earlier, PAT with block is digitalis-induced in about one-half of the cases. On the other hand, nonparoxysmal AV nodal tachycardia is almost always due to digitalis and indicates a high degree of digitalis toxicity. ◄

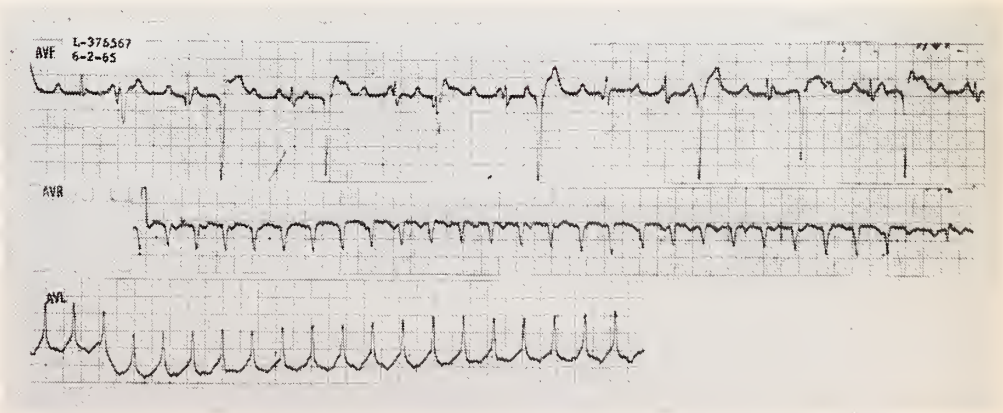


FIGURE 1

THIS tracing demonstrates a triple arrhythmia including paroxysmal atrial tachycardia, nonparoxysmal nodal tachycardia and ventricular premature systoles.

X-RAY CONFERENCE

Presented as a regular feature of *The Journal*, X-ray Conference is a series of short talks on procedure and radiologic diagnosis, edited by Erich K. Lang, M.D.

The Value of Selective Renal Arteriography In the Assessment of Renal Hypertension

ERICH K. LANG, M.D.
*Indianapolis**

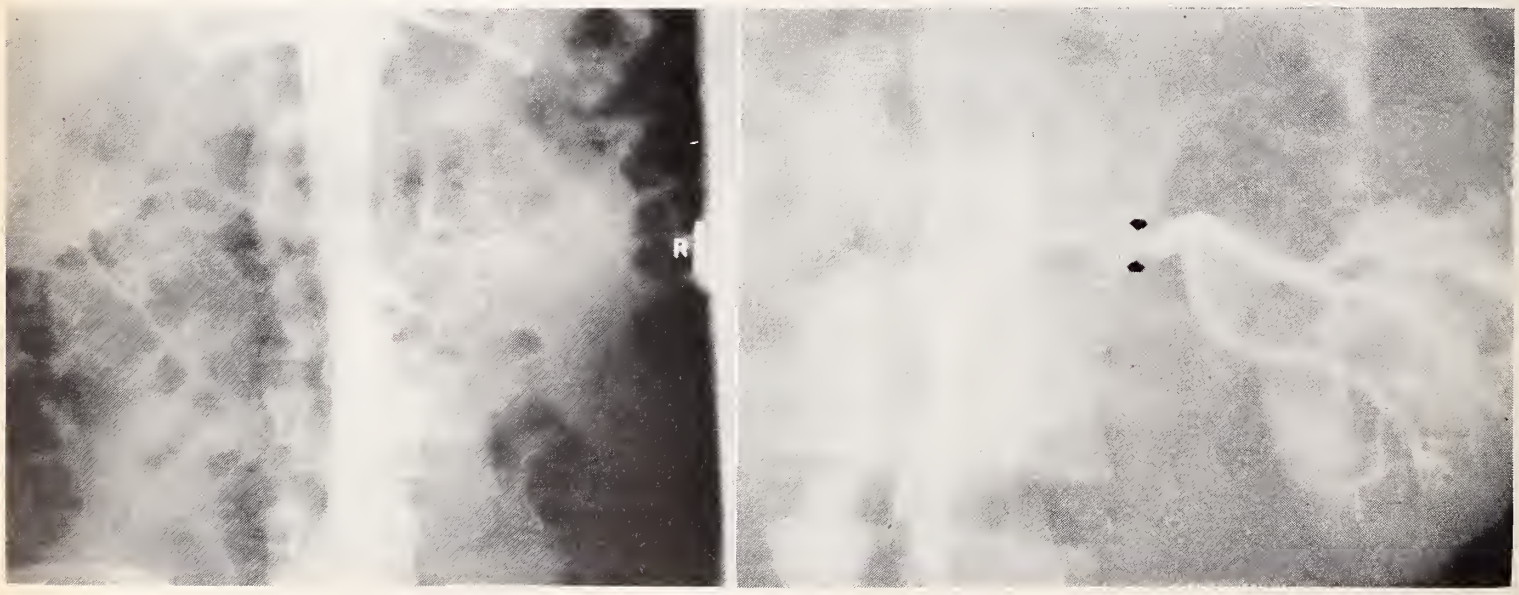
A 36-year-old colored female was admitted to Methodist Hospital with a history of hypertension. The patient was first discovered to have hypertension during her fourth pregnancy. She was hospitalized for the last trimester because of pre-eclampsia. After delivery, she was placed on antihypertensive medication. However, the hypertension was never well controlled and during the ensuing years, a malignant hypertension developed.

Physical examination revealed hypertensive retinopathy; blood pressure of 230/140 appeared to be fixed. Bedrest did not result in lowering of the blood pressure.

Intravenous pyelograms revealed a disparity in the nephrographic stain of the right and left kidneys; the right kidney stained more intensely than its left counterpart. On the late phase film, the dye concentration in the left kidney was greater than on the right side. These findings suggested the presence of arterial disease of the left kidney.

A flush arteriogram performed with a pigtail catheter failed to reveal any significant arterial disease of either the right or left renal arteries (Figure

*Department of Radiology, Methodist Hospital, Indianapolis.



FIGURES 1-A AND B

THE flush injection with a pigtail catheter demonstrates the aorta and the renal arteries (1-A). A double supply to the left kidney is noted. However, a significant lesion is not identified. Selective injection of the artery supplying the lower pole of the left kidney shows an area of concentric narrowing (1-B). The hemodynamic significance of this lesion is emphasized by a mild post-stenotic dilatation. A small aneurysm of one of the end arteries in the lower pole is noted. This raises the question of periarthritis nodosa.

1-A). An accessory artery supplying the lower pole of the left kidney was demonstrated, but this vessel appeared to be normal.

All subsequent clinical and laboratory examinations failed to reveal any significant abnormalities. Howard and Stamey differential excretion studies were carried out and again incriminated the left kidney. In view of consistently abnormal findings suggesting an arterial lesion of the left kidney, the patient was restudied by selective catheterization of the renal arteries.

On this attempt a classical constricting lesion of the accessory left renal artery supplying the lower pole was demonstrated (Figure 1-B). The lumen of the artery was narrowed to less than 30% of normal. In the AP projection, the narrowed segment was superimposed upon the main artery supplying the upper one-half of the kidney and hence could not be demonstrated on the preceding arteriographic study. The value of selective renal arteriography is emphasized by this experience.

Discussion

The value of renal arteriography by selective engagement of the various renal arteries with a catheter and flush injection is demonstrated by this case. Frequently small lesions may not be appreciated on the flush injection because of other superimposed vessel groups, particularly of the celiac axis group and of the mesenteric artery. Selective renal arteriography allows a selective assessment of the renal arteries alone. The disadvantage of the method, however, is failure of adequate demonstration of the very orifice of the renal arteries from the aorta; an area which is afflicted with 40% of all constricting lesions. A flush injection should be carried out in conjunction with selective renal arteriography to assess the very origin of the renal arteries from the aorta. Selective renal angiography is technically very simple; a curved tip catheter allows easy and rapid engagement of the renal vessels. ◄

ASTHMA: IMMUNOLOGICAL AND NON-IMMUNOLOGICAL

One of a series of case reports illustrating the differential diagnosis in patients with symptoms of asthma.

IRVIN CAPLIN, M.D.
JOHN T. HAYNES, M.D.
Indianapolis

A six-year-old boy was referred to our office because of "asthma" of three years duration. There was no seasonal variation, although he was worse during the winter months of the year. As an infant he suffered from croup; upper respiratory infections were frequent and he coughed a great deal every night, winter and summer. Stools were large, fatty in appearance and foul smelling. He had been ill so much that he was forced to drop out of school. There was allergic disease on both sides of the family.

Physical examination revealed a thin, sickly looking child with sallow skin. The teeth were stained yellow with black and gray streaks similar to those described from tetracycline therapy. Rhonchi were heard throughout both lung fields. The typical expiratory musical rales of asthma were not present. The abdomen was distended. The liver was enlarged two fingerbreadths below the costal margin. The spleen was also palpable. The fingers were clubbed and the nail beds cyanotic.

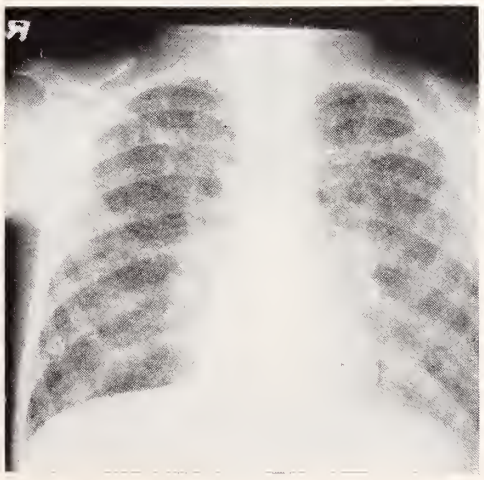


FIGURE 1
DIFFUSE inflammatory changes associated with cystic fibrosis of the pancreas are evident.

The chest x-ray (Figure 1) revealed diffuse inflammatory changes involving both lung fields. A sweat chloride was 109 milliequivalents. (Normal is less than 60 milliequivalents). A diagnosis

of cystic fibrosis of the pancreas was made.

Case Report No. 2

A 15-year-old girl was first seen three years ago for "asthma." History at that time did reveal asthma and pneumonia which started at age six months. Duodenal drainage revealed no evidence of pancreatic enzymes and a diagnosis of cystic fibrosis of the pancreas was made. She had been treated with pancreatic enzymes and antibiotics. The parents joined the State Cystic Fibrosis League and had accepted the fact that their child would probably not live to adulthood. However, she grew normally. The family noted that although her attacks were perennial, they were worse during the grass and ragweed season.

Physical examination revealed a healthy 12-year-old girl with moderate asthma. Skin tests were positive to dust, feathers, cattle hair, ragweed, grasses, elm and several molds. Sweat chloride was 15 milliequivalents. She was treated with dust, molds, ragweed, grasses and elm tree pollen. Her asthma has been completely controlled for three years and treatment is to be discontinued.

Case Report No. 3

A four-year-old boy was seen in consultation for his asthma. A diagnosis of cystic fibrosis of the pancreas had been made during infancy because of frequent large fatty stools, frequent respiratory infections and rhonchi throughout his chest. A sweat chloride test was 150 milliequivalents per liter.

During infancy the parents noted that milk and milk products produced nasal congestion and vomiting. He was placed on Nutramigen with complete clearing of symptoms. For the preceeding three years it was noted that his "asthma" became worse during the summer months. He had been hospitalized in status asthmaticus the previous two ragweed seasons. Steroids were necessary to control his asthma. His doctor, who had been seeing many patients with cystic fibrosis, felt his wheezing was different from that heard in children with cystic fibrosis alone. When seen in December of 1964, he had been on cortisone for six months.

Family history revealed allergic disease on both sides of the family. Physical examination revealed the nasal mucosa to be pale, boggy and swollen. The teeth were poor. There was a marked increase in the A-P diameter of the chest. Expiratory musical rales were present throughout both lung fields. The abdomen was protuberant and the liver margin was palpable two finger breadths below the costal margin.

Skin tests were positive to dust, dog hair, feathers, wool, ragweed, grasses and several molds.

On a program of avoidance of dust and other household allergens, as well as hyposensitization with dust, pollens and molds, it was possible to control this child's asthma and discontinue the use of steroids. Again, we have a patient with two diseases. The control of the allergic component resulted in an overall improvement in his general health.

This unhappy disease was almost unknown ten years ago. A monograph[1] on the subject written in 1954 does not even mention sweat chlorides. Recently, the British[2] described adults with chronic pulmonary disease and elevated sweat chlorides. Our knowledge of this disease is in its infancy. This disease must be added to an already voluminous list one must consider to differentiate allergic from non-allergic asthma.

REFERENCES

1. May, Charles D.: *Cystic Fibrosis of the Pancreas in Infants and Children*, Charles C Thomas Publishers, Springfield, Ill., 1954.
2. Karlish, A. J., Tarnoky, A. L.: Mucoviscidosis and Chronic Lung Disease in Adults, *Amer. Rev. Resp. Dis.* 88:810, Dec., 1963. ◄

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Rx Labeling*

ONE of the factors which points to the fact that pharmacists providing pharmaceutical services to nursing homes must be aware that there are some important differences between private patients and institutionalized patients is the matter of placing the name and strength of the drug on the prescription label. For years the question of whether the pharmacist should be required to place the name and strength of the drug on the label of prescriptions dispensed to private patients in community pharmacies has been discussed by pharmacists and physicians both privately and at meetings of their professional societies. At the 1963 I.Ph.A. convention Resolution No. 13, dealing with the subject, was adopted. It expressed the view of the I.Ph.A. that "In the absence of a specific request from the prescriber, a pharmacist should not by himself, or upon request by a patient, *ordinarily* disclose by labeling the ingredients of prescription medication." [emphasis added]

The fact must be remembered that in a health care institution such as a hospital or nursing home, the patients do not administer their own medications. Professionally trained persons handle the medication containers and have a legitimate reason to want to be able to positively identify the drugs which they handle.

The Indiana Health Facilities Licensing Council has recommended that steps be taken to encourage pharmacists serving patients in nursing homes to place the name and strength of the ingredients on the prescription label. In Wisconsin, where until a short time ago it was illegal for pharmacists to place this information on prescription labels without the express consent of the prescriber, it is now mandatory for any community pharmacist who sends medication to a nursing home to identify the name of the drug and the dosage on the label. This avoids the situation which is found in some cases where someone at the nursing home places the name of the drug on the label based on information gained by comparison with other drugs in the patient's medicine drawer, or by calling the pharmacist on the phone. The labeling of a prescription is a responsibility of the pharmacist and should not be delegated to untrained persons who are not under the supervision of a pharmacist.

It is strongly recommended that pharmacists serving nursing home patients in Indiana adopt the practice of placing the name and strength of the drug on the prescription label. I do not believe that this would be in violation of the law or of the I.Ph.A. policy quoted above. If the pharmacist wishes to obtain written permission from the prescriber to place this information on the labels of all prescriptions sent to nursing homes, he can do so by phone or by utilizing a form letter and reply card. Such a form appears on page 113 of the *Proceedings of the Conference on Pharmaceutical Services to Nursing Homes*, available at $2 from The Ohio State University College of Pharmacy, Columbus, Ohio 43210. — James D. Hawkins, Executive Secretary, Indiana Pharmaceutical Assn., Inc. Reprinted from *The Indiana Pharmacist* 47:56, March, 1966.

*The Indiana Health Facilities Council is distributing reprints of this editorial to all Indiana nursing homes.

Parameter

One of the *Lancet's* Peripatetic Correspondents suggested a year or two ago in a delightful little article that the word "parameter" was foisted upon the medical profession by an evil old word-merchant because a medical writer complained to him that the last vogue word he had gotten from him — serendipity — was getting pretty threadbare, and didn't puzzle anybody any more. Said the old word-merchant, "I have just the word for you: it looks

so simple, everyone who sees it will be sure he ought to know what it means, from his high school Latin, and no one will have the courage to admit it if he doesn't, even though almost no one will understand it. The word is 'parameter.' "

The most concise definition of "parameter" appears to be "quantity constant in case considered, but varying in different cases."[1] One Webster[2] says it's "a quantity to which the operator may assign arbitrary values, as distinguished from a variable, which can assume only those values that the form of the function makes possible."

Webster III says it's "an independent variable through functions of which other functions may be expressed."

Mr. O'Leary, upon whom Dr. Joseph Garland of the *New England Journal of Medicine* relies for these matters, just says it means "independent variable" (and, of course, he can prove it). Dr. Garland himself says "it's a lovely word, but getting shopworn," and he adds, "I don't understand it."[3]

Well, we don't understand it, either. We can hardly understand "independent variable"; at least, we couldn't distinguish it from a dependent variable. What's more, we don't believe over one man in ten who writes or says "parameter" understands it.

We think it is being used, most of the time, as an impressive substitute for a simple, homely, lucid word like "dimension," or "factor," or "measure." Perhaps, some of these times, it really is an "independent variable" — whatever that may be. Even if it is, this seems like a poor excuse for being obscure. — **Harry L. Arnold, Jr., M.D., editor,** *Hawaii Medical Journal* 25:401, May-June, 1966. ◀

1. *The Concise Oxford Dictionary of Current English*, ed. 4, Oxford, 1952.
2. *Webster's New Collegiate Dictionary*, G. & C. Merriam, 1956.
3. Garland, J.: Personal communication, 1966.

The Need for Medical Testimony (I)

ROBERT E. HALES, M.D.
Oaklandon

HOPEFULLY every physician will at some time come into contact with the law! Preferably, of course, through the need for medical testimony as the need is great. The stakes are high for our patients. But do we always respond? I think not.

Between 70 and 80% of all trials depend on medical testimony — involving substantial issues of medical proof.

The April, 1966, issue of this journal carried a guest editorial which criticized physicians as sometimes being prejudicial expert medical witnesses.

I submit that a more important problem in this area involves the ability of our patients and their attorneys to obtain any medical testimony whatsoever.

The fact that attorneys on both sides, through the use of subpoena power, can command the doctor to lay aside any excuse or pretense and appear in court does little to solve the problem or promote good feelings. Compulsory appearances and compulsory testimony are not what the patient's attorney is looking for. Such testimony is elicited under the threat of punishment for contempt of court. Such an unwilling physician will probably not have had a preliminary conference with the attorney in order to get the gist of forthcoming questions.

Confusing testimony, of course, is worse than none at all. It may be more injurious to the patient's case than moderately prejudiced medical testimony. It will hurt the doctor's reputation and therefore indict the entire medical profession. Again, I submit that the need for medical testimony is as important a need as any other problem with which our patients may confront us.

Most triers of fact have no difficulty in assessing the amount of damage to an automobile. But what about the extent of injuries to the human beings involved in the accident? This is an issue totally dependent upon medical testimony.

Physicians are reluctant to become involved. We have had no training in the law; we distrust lawyers. Interruptions to our practice are viewed with distaste.

But what about our patients who depend upon us for medical testimony? Can we simply refuse them their needs which are so dependent upon our opinions? Certainly our responsibility to our patients entails more than just competent medical treatment alone. Evaluation of disabilities which often affect the breadwinner's ability to make his livelihood makes it mandatory for physicians to provide more than medical treatment. How can a jury decide matters of personal injury, pain, suffering and disability without our opinion?

General practitioners are legally considered to be experts and, when compared with laymen, *are* experts upon medical matters. Therefore, it is not only the specialist who should testify when called upon.

In addition, we have a moral duty to give our evaluation and opinion upon medical matters that involve people we have never treated. Indeed, in some instances, we should give medical opinion upon matters that involve people we have never seen before!

Of course, in 37 states (Indiana included) the doctor-patient privilege allows the patient not to let his doctor disclose any information obtained in attending him. The rationale here is that public policy encourages patients to be truthful with their doctors, which tends to preserve harmony. This is all the more reason we should do our utmost to preserve our faltering image by helping our patient.

Our Constitution guarantees citizens the right to have a jury trial. To prove liability in a personal injury action, a person, often our patient, must prove

a causal connection between injury and trauma. The jury may be told that the patient previously had the condition which he claims is due to the accident. The physician who knows his patient's medical background is called upon to supply much needed testimony. The judge and jury need our help as well as the patient; the case must be decided and its outcome depends largely on medical testimony.

Another important area which often involves medical testimony is the multitude of workman's compensation cases. In compensation hearings the doctor is the most important witness. What may have caused the patient's condition? Is there incapacity? Did the injury likely arise out of the patient's employment? Could it have? The judge and jury are waiting. So is our patient. Often the stakes are very high.

Such is the practice in our courtrooms, the nature of our laws, our adversary system and, in fact, the heritage of our country.

Oaklandon Medical Clinic
Oaklandon, Ind.

(To be concluded next month.)

Editorial Notes...

Eli Lilly and Company have perfected a system of printing each of their tablets and capsules with a combination of one letter and two numbers in such a way as to make each medication and each dosage form identifiable. The system is called Identi-Code. Code booklets will be distributed to doctors, dentists, pharmacists, nurses, law enforcement agents, poison-control centers and all others who deal with medical emergencies. It is expected that the code will be of especial importance in the identification of plain white tablets.

"LONDON—By a curious coincidence, on July 1 the U. S. will take its first step toward socialized medicine and Britain will take its biggest step away from it. On the same day medicare goes into effect for senior American citizens, all British subjects, old or young, will be offered a paying alternative to the free National Health Service. A company called Independent Medical Services, Ltd., will seek to sell Britons for cash what they have been getting free from the welfare state for nearly two decades. In this apparently quixotic undertaking it enjoys the backing of the British Medical Association, of which the vast majority of this country's doctors are members . . . . Executives of Independent Medical Services recently told *Barron's* that public opinion surveys showed 30% to 40% of Her Majesty's subjects are not satisfied with free cradle-to-grave state medicine. They would prefer to make private arrangements with a family doctor. The firm, for a moderate charge, will enable them to do just that . . . ." (*Barron's National Business and Financial Weekly*, June 20, 1966).

New medicines introduced by the American drug industry have declined sharply to the lowest point in 25 years. Only four new single chemical entities have been approved for marketing in 1966. Single chemical entities introduced during the first six months of each year from 1961 to 1966 inclusive number as follows: 24-14-8-8-14-4. The total of all new introductions for the same years are: 154-125-89-98-55-39.

Dr. W. D. Snively of Mead Johnson is the senior author of an article appearing in the JAMA for July 18 describing a simple method of determining the body surface area of a child. Surface area is sometimes a better criterion than weight or age for determining amounts of water and electrolytes and dosage of drugs. Surface area may be resolved by measuring the sitting height of the child in centimeters, squaring the number obtained and multiplying by .00018. The result of this equation is the metric measurement of body surface. Greater accuracy is obtained by using .00017 for children under six months, and .00019 for older children.

The Indianapolis VA Hospital is one of 36 VA hospitals which maintain nursing care beds. More than 2,000 such beds are provided in the U. S.; the Indianapolis hospital has 46 of them. As the total of older veterans increases, the demand for long-term care has increased proportionately. This type of patient now comprises one-third of all VA admissions. The VA is also assigning older veterans to private nursing homes for extended care.

The BIG IDEA with seat belts is not to get people to buy them, but to use them. A California study by HEW shows that only two-thirds of seat belt owners use them on highway driving, and only one-third use them in town. A large number of auto fatalities occur within a few miles of home; belts are as valuable for short trips as for long ones. HEW says that if everyone used belts all the time, the U. S. would lose 5,000 fewer people every year and save a quarter million hospitalizations per year.

Title 19, the part of the Medicare Bill now called Medicaid, and which provides a joint federal-state payment for medical care for the "medically needy" of all ages and allows the states to set the limits of eligibility, was passed under an HEW estimate of cost for all states of $238 million. New York state has already set their limits and passed their law; $217 million will be required in federal funds for New York alone. Eight other states have also passed Medicaid laws: expenditure for the nine states is estimated at $620 million annually. Ralph Harvey, Congressman from the 10th District, estimated that by the time 50 state programs are legislated, 35 million people will be involved in Title 19 and the tag will be for $2 billion or more.

new

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Dialog is well tolerated, even by those sensitive to aspirin. It is nonirritating to the gastrointestinal tract and has no adverse effects on the kidneys.

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- Reduces emotional tension

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Indications: For relief of pain and discomfort of simple headache; neuralgia, myalgia, and musculoskeletal pain; dysmenorrhea; bursitis; sinusitis; fibrositis. Also indicated to reduce fever and to relieve discomfort due to respiratory infections, influenza, and other febrile conditions.

Contraindication: Not recommended during pregnancy.

Caution: May be habit-forming. Do not use in patients sensitive to barbiturates or in those with moderate to severe hepatic disease.

Side Effects: Nausea, transitory dizziness, rash. Overdosage of allobarbital produces symptoms typical of acute barbiturate excess.

Dosage: *Adults:* 1 or 2 tablets every 4 hours. Not to exceed 8 tablets in 24 hours. *Children 6 to 12:* ½ to 1 tablet every 4 hours. Not to exceed 4 tablets in 24 hours.

Supplied: *Tablets* (white, scored), each containing 15 mg allobarbital and 300 mg acetaminophen; units of 3 bottles of 30.

For your convenience—prescription-size bottle of 30.

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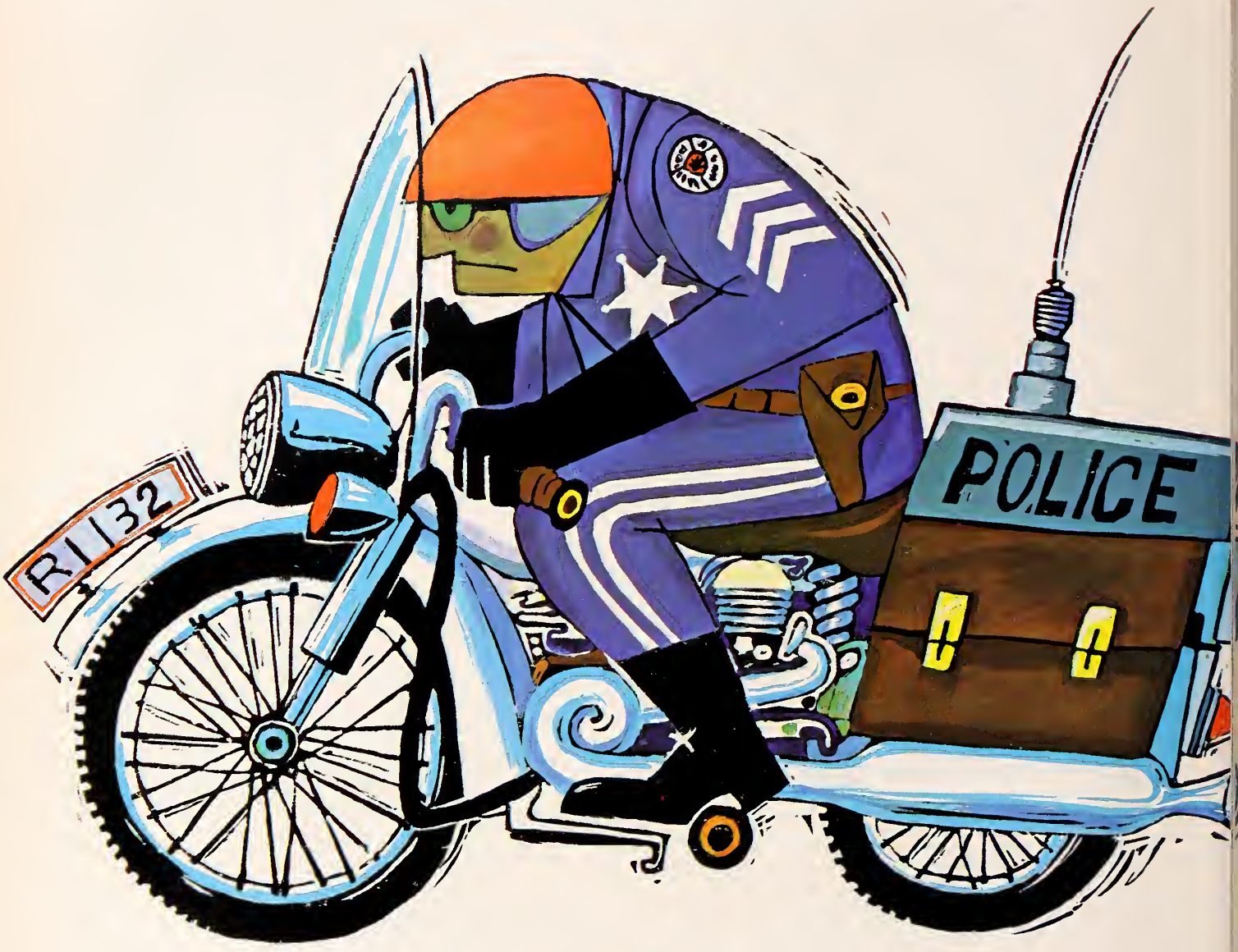
C I B A

arrest diarrhea



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atropine sulfate . . . . . 0.025 mg.

Effectiveness: Lomotil possesses a unique degree of effectiveness in both acute and chronic diarrhea.

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Versatility: The therapeutic efficiency, safety and convenience of Lomotil may be used to advantage alone or as adjunctive therapy in diarrhea associated with:

- **Ulcerative colitis**
- **Acute infections**
- **Irritable bowel**
- **Regional enteritis**
- **Drug therapy**
- **Food Poisoning**
- **Functional hypermotility**
- **Malabsorption syndrome**
- **Ileostomy**
- **Gastroenteritis and colitis**

Dosage: For correct therapeutic effect—Rx correct therapeutic dosage. The recommended initial daily dosages, given in divided doses, until diarrhea is controlled, are:

Children: Age	Total Daily Lomotil Dosage	Lomotil Liquid Dosage (Each teaspoonful [4 cc.] contains 2 mg. of diphenoxylate HCl)
3-6 months	3 mg.	½ tsp. 3 times daily
6-12 months	4 mg.	½ tsp. 4 times daily
1-2 years	5 mg.	½ tsp. 5 times daily
2-5 years	6 mg.	1 tsp. 3 times daily
5-8 years	8 mg.	1 tsp. 4 times daily
8-12 years	10 mg.	1 tsp. 5 times daily

Adults: 20 mg. (2 tsp. 5 times daily or 2 tablets 4 times daily) Based on 4 cc. per teaspoonful. Maintenance dosage may be as low as one-fourth the initial daily dose.

Precautions: Lomotil, brand of diphenoxylate hydrochloride with atropine sulfate, is a Federally exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded. Lomotil should be kept out of reach of children since accidental overdosage may cause severe respiratory depression. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates. The subtherapeutic amount of atropine is added to discourage deliberate overdosage.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness, insomnia, numbness of extremities, headache, blurring of vision, swelling of the gums, euphoria, depression and general malaise.

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Contraindications: Dextro-amphetamine sulfate: in hyperexcitability and in agitated prepsychatic states. Previous allergic or idiosyncratic reactions to meprobamate.

Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness.

Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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President's Page

With the approach of the fall season, the entire ISMA organization begins counting the days until the annual convention. This year for a change of pace, the meeting will be in French Lick, with ample time for rest and recuperation. The program has been purposely geared to provide a "breather" for everyone.

The annual meeting provides an opportunity for all of the members, as well as the delegates, to express their opinions before the Reference Committees. From the many letters I have had this year, I feel sure many of you will want to take the opportunity to appear before the Reference Committees and present your views. Your opinions will be studied by the Reference Committees and reported to the House of Delegates and the decisions of the House will then become the policies of the ISMA.

As I promised in my speech at the last annual meeting, I have attempted to maintain these previously adopted policies throughout the year and I have had the cooperation of all the officers and staff.

Many of you have taken exception to these policies which have previously been adopted. This annual meeting is your opportunity to present your views. Those of you agreeing with previous policies should re-affirm your position. I would hope that when a majority of our members delegates adopt a policy, all would support it. It is difficult for your officers to adhere to certain programs when they have only token support of the members.

The fragmentation of medicine has been encouraged in the past year by those who were willing to "talk" but not "do." This fragmentation is encouraged by those who would weaken medicine in order to gain control of it for their selfish gains. We must be careful to adopt only carefully thought-out policies that can guide the future of medicine.

It is difficult for your officers to "go forth and do battle" when the "troops" are divided. The past few years have been difficult ones, and the immediate future does not appear to be any different.

I am grateful to those of you who have expressed your support of our efforts. For those of you thinking otherwise, I can only say that all of my efforts were based upon policy adopted by "your" House of Delegates.

H. O. Neumann M.D.

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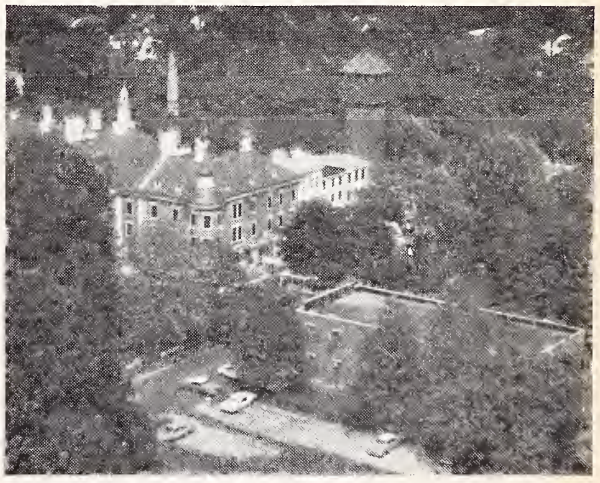

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The Woman's Auxiliary

REPORTS TO ISMA

An urgent appeal will go out to every Hoosier doctor's wife to attend your state convention in French Lick. Now we ask you to help them to be there. Your association needs you there and the auxiliary has an interesting and important program planned for your wives.

Our presiding officers and six state chairmen (Community Service, Mental Health, Membership, Health Careers and AMA-ERF) will have just returned from the North Central Regional Workshop in Chicago. They will be "brimming over" with enthusiasm and program plans which national has prepared. In the words of our national president, Mrs. Asher Yaguda, "We are, basically, involved with the subjects of the health of children and youth of school age, and, on the opposite end of the spectrum, with the incapacitating illnesses and their effect on the aged. We are not forgetting those in-between . . . Youth may appear to be the more demanding because ours is a youth-focused nation. The unvoiced needs of our eighteen million older citizens have brought a new dimension to medical practice. Their needs and their numbers require that we, who support our physician husbands by serving our communities, assist in providing the services needed for the elders' total care."

The workshop on Wednesday, October 12, is a *must* for every county president, president-elect and chairman. All other members and members-at-large will miss a most interesting and informative day if they are absent. At noon will be our annual luncheon with door prizes and entertainment.

Come to French Lick, doctors, and bring your wives along for several days of fun, relaxation and fellowship.

Mazo D. Scales

117th
Annual Convention

INDIANA STATE MEDICAL ASSOCIATION

October 10, 11, 12, and 13, 1966
All Events on Eastern Standard Time
French Lick-Sheraton Hotel
French Lick, Indiana

Complete Program and
Annual Reports on
Following Pages

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Official Call to the House of Delegates

The next annual session of the Indiana State Medical Association will be held at the French Lick-Sheraton Hotel, French Lick, Indiana, October 10, 11, 12 and 13, 1966.

The House of Delegates will be constituted as follows: Marion County, 21 delegates; Lake County, eight delegates; Allen County, six delegates; St. Joseph and Vanderburgh county societies, each five delegates; Delaware-Blackford, three delegates; Bartholomew-Brown, Daviess-Martin, Dearborn-Ohio, Elkhart, Fayette-Franklin, Fountain-Warren, Harrison-Crawford, Jackson-Jennings, Jefferson-Switzerland, LaPorte, Madison, Owen-Monroe, Parke-Vermillion, Tippecanoe, Vigo and Wayne-Union county societies, each two delegates; the other 58 county societies, each one delegate; 13 councilors, and the ex-presidents, namely, F. S. Crockett, Herman M. Baker, Karl R. Ruddell, M. A. Austin, Paul D. Crimm, W. Harry Howard, Walter U. Kennedy, Elton R. Clarke, M. C. Topping, Kenneth L. Olson, Earl W. Mericle, Guy A. Owsley, Maurice E. Glock, Donald E. Wood and Joseph M. Black, and ex-officio, the president, president-elect, executive secretary and the treasurer of the association, and the delegates to the American Medical Association, all without power to vote, except in the case of a tie vote, when the president shall cast the deciding vote.

All delegates have been certified by their county medical societies. No delegate will be seated unless wearing the official badge.

The House of Delegates will convene promptly at 2:00 p.m., Monday, October 10, 1966, in the North Convention Hall, French Lick-Sheraton Hotel, and again at 8:30 a.m., Thursday, October 13, 1966, in the West Dining Room, French Lick-Sheraton Hotel (breakfast meeting).

The order of business will be as follows:

1. Call to order by the president.
2. Invocation.
3. Roll call and seating of qualified delegates.
4. Tribute to members of House who have died since the 1965 session.
5. Reading of the minutes of previous meetings.
6. Introduction of guests.
7. Appointment of Reference Committees and assignment of meeting rooms.
8. Unfinished business.
9. Address of president-elect.
10. Report of president of the Woman's Auxiliary.
11. Report of Indiana Chapter Student AMA.
12. Report by president of Blue Shield.
13. Report of executive secretary.
14. Report of treasurer.
15. Report of the chairman of the Council.
16. Reports of councilors.
17. Report of *Journal* editor.
18. AMA Delegates' report.
19. Report of State Board of Medical Registration and Examination.
20. Reports of committees and commissions:

    COMMITTEES:

    (1) Executive
    (2) Grievance
    (3) Student Loan
    (4) Medical-Legal Review
    (5) Building

    COMMISSIONS:

    (1) Convention Arrangements
    (2) Constitution and Bylaws
    (3) Legislation
    (4) Public Information
    (5) Governmental Medical Services
    (6) Public Health
    (7) Voluntary Health Agencies
    (8) Inter-Professional Relations
    (9) Medical Economics and Insurance
    (10) Medical Education and Licensure
    (11) Special Activities
    (12) Aging

21. New Business
    (1) Resolutions

The election of officers will be the first order of business at the second meeting of the House of Delegates. In addition to the regular officers, the terms of the following officers expire December 31, 1966, and their successors must be elected at the session: Delegates to the American Medical Association to succeed Harold C. Ochsner, Indianapolis, E. S. Jones, Hammond and Francis L. Land, Fort Wayne.

Delegates from the Second, Fifth, Eighth and Eleventh Districts are reminded that the terms of their councilors will expire October 13, 1966, and new councilors should be elected to succeed the following:

Second District — E. T. Edwards, Vincennes.
Fifth District — V. Earle Wiseman, Greencastle.
Eighth District — Donald R. Taylor, Muncie.
Eleventh District — Lowell Hillis, Logansport.

Some of these elections already may have been held, but they should be reported to the House of Delegates at this session for confirmation. ◄

JAMES A. WAGGENER, *Executive Secretary*

HOUSE OF DELEGATES

Indiana State Medical Association

French Lick-October 10, 11, 12 and 13, 1966

County and Delegates	Alternates
ADAMS (1)	
ALLEN (6)	
W. Lloyd Bridges, Fort Wayne	F. W. Dahling, New Haven
J. L. Andrew, Fort Wayne	C. H. Aust, Fort Wayne
Edward D. Miller, Fort Wayne	W. T. Jurgensen, Fort Wayne
J. S. Farquhar, Fort Wayne	E. E. Stumpf, New Haven
Richard B. Juergens, Fort Wayne	R. L. Hillery, Fort Wayne
Richard G. Fullam, Fort Wayne	G. R. Nolan, Fort Wayne
BARTHOLOMEW-BROWN (2)	
Harold W. Richmond, Columbus	Lloyd Gammell, Columbus
Robert M. Seibel, Nashville	Floyd Thurston, Nashville
BENTON (1)	
Donald L. McKinney, Otterbein	Thomas J. Stolz, Otterbein
BOONE (1)	
Clarence G. Kern, Lebanon	James R. McAfee, Lebanon
CARROLL (1)	
T. Neal Petry, Delphi	
CASS (1)	
Earl W. Bailey, Logansport	
CLARK (1)	
Eli Goodman, Charlestown	William R. Greene, Henryville
CLAY (1)	
Rahim Farid, Brazil	
CLINTON (1)	
Robert A. Hedgcock, Frankfort	Harry T. Stout, Frankfort
DAVIESS-MARTIN (2)	
C. Philip Fox, Washington	Robert H. Rang, Washington
E. B. Lett, Loogootee	Robert E. Chattin, Loogootee
DEARBORN-OHIO (2)	
Leslie M. Baker, Aurora	Ivan Lindgren, Lawrenceburg
Gordon S. Fessler, Rising Sun	Amado Mauricio, Rising Sun
DECATUR (1)	
William Shaffer, Greensburg	
DE KALB (1)	
Bradley Hughes, Waterloo	Clifford Shultz, Butler

County and Delegates	Alternates
DELAWARE-BLACKFORD (3)	
Thomas M. Brown, Muncie	Clyde G. Botkin, Muncie
Glynn B. Rivers, Muncie	Ross L. Egger, Middletown
Dean B. Jackson, Hartford City	Richard Ingram, Montpelier
DUBOIS (1)	
Thomas Gootee, Jasper	John Barrow, Dale
ELKHART (2)	
Edward G. Dovey, Elkhart	James D. Finfrock, Elkhart
Burton E. Kintner, Elkhart	Frederick W. Bigler, Goshen
FAYETTE-FRANKLIN (2)	
William F. Kerrigan, Connersville	A. M. Hudson, Connersville
H. N. Smith, Brookville	Perry Seal, Brookville
FLOYD (1)	
Irvin H. Sonne, New Albany	Everett Bickers, Floyd Knobs
FOUNTAIN-WARREN (2)	
Max Hoffman, Covington	Lowell Stephens, Covington
Carl Nelson, West Lebanon	
FULTON (1)	
Dean K. Stinson, Rochester	Charles Richardson, Rochester
GIBSON (1)	
William E. Dye, Oakland City	Virgil McCarty, Princeton
GRANT (1)	
Robert M. Brown, Marion	Lester L. Renbarger, Marion
GREENE (1)	
Harry G. Rotman, Jasonville	John W. Woner, Linton
HAMILTON (1)	
Joseph R. Lloyd, Noblesville	
HANCOCK (1)	
Wayne H. Endicott, Greenfield	
HARRISON-CRAWFORD (2)	
Louis H. Blessinger, Corydon	
Jesse C. Benz, Marengo	
HENDRICKS (1)	
Malcolm O. Scamahorn, Pittsboro	Lloyd Terry, Danville
HENRY (1)	
Kenneth G. Hill, New Castle	William C. Heilman, Jr., New Castle

County and Delegates	Alternates
HOWARD (1)	
Warren M. McClure, Kokomo	Richard W. Halfast, Kokomo
HUNTINGTON (1)	
Richard W. Wagner, Huntington	Warren Van Campen, Huntington
JACKSON-JENNINGS (2)	
Forrest Ellis, North Vernon	Shaffer B. Berkshire, North Vernon
Harry R. Baxter, Seymour	William D. Schai-brough, Ewing
JASPER (1)	
Kenneth R. Ockermann Rensselaer	Earnest R. Beaver, Rensselaer
JAY (1)	
James Fitzpatrick, Portland	
JEFFERSON-SWITZERLAND (2)	
Robert O. Zink, Madison	Frank W. Hare, Madison
Noel Graves, Vevay	Antha Hamilton, Vevay
JOHNSON (1)	
Joseph Young Greenwood	
KNOX (1)	
Herbert O. Chattin, Vincennes	
KOSCIUSKO (1)	
William J. Cron, Warsaw	Thomas F. Keough, Warsaw
LA GRANGE (1)	
Philip E. Yunker, Howe	Kenneth Lehman, Topeka
LAKE (8)	
Philip J. Rosenbloom, Gary	J. J. Sala, Gary
George Thegze, East Chicago	Richard J. Purcell, Griffith
Jacob Pruitt, Gary	C. T. Disney, Gary
	Walfred Nelson, Gary
H. W. Eggers, Munster	E. A. Campagna, East Chicago
D. B. Templin, Lowell	William J. Fitzpatrick, Munster
V. J. Santare, Munster	Nicholas Egnatz, Hammond
C. O. Almquist, Gary	Daniel T. Ramker, Hammond
LA PORTE (2)	
G. O. Larson, LaPorte	J. C. Richter, LaPorte
Thomas D. Armstrong, Michigan City	Frank McGue, Michigan City
LAWRENCE (1)	
Joseph C. Dusard, Bedford	John W. Reuter, Bedford
MADISON (2)	
P. T. Lamey, Anderson	R. D. Williams, Markleville
Horace Jones, Anderson	Robert V. E. Drennen, Anderson
MARION (21)	
John O. Butler, Indianapolis	Rex M. Joseph, Indianapolis
Sprague H. Gardiner, Indianapolis	E. Jane Brownley, Indianapolis
David Hadley, Indianapolis	F. Robert Brueckmann, Indianapolis
James M. Leffel, Indianapolis	Joseph M. Daly, Indianapolis
Michael W. Manzie, Indianapolis	Fred L. Toumey, Indianapolis
Roland B. Rust, Jr., Indianapolis	David Lozow, Indianapolis
Morris E. Thomas, Indianapolis	Robert W. Mouser, Indianapolis
Albert M. Donato, Indianapolis	John A. Robb, Indianapolis
Joseph C. Finneran, Indianapolis	Berj Antreasian, Indianapolis
James H. Gosman, Indianapolis	Austin L. Gardner, Indianapolis
Myron H. Nourse, Indianapolis	Carroll W. Hasewinkel, Indianapolis
Dwight W. Schuster, Indianapolis	Edwin S. McClain, Indianapolis
Donald E. Stephens, Indianapolis	Dennis Nicholas, Indianapolis
Donald E. Wood, Indianapolis	John S. Schechter, Indianapolis
Joseph L. Haymond, Indianapolis	Richard A. Brickley, Indianapolis
Jack W. Hickman, Indianapolis	W. Stanley Garner, Indianapolis
William A. Karsell, Indianapolis	John D. Graham, Indianapolis
Thomas E. Lunsford, Indianapolis	Kenneth L. Gray, Indianapolis
Louis W. Nie, Indianapolis	M. Richard Harding, Indianapolis
Hunter A. Soper, Indianapolis	Robert F. Nagan, Indianapolis
Charles E. Test, Indianapolis	Henry G. Nester, Indianapolis
MARSHALL (1)	
Robert Reed, Plymouth	Joseph Howard, Culver
MIAMI (1)	
Lloyd Hill, Peru	James U. Guthrie, Peru
MONTGOMERY (1)	
Richard R. Eggers, Crawfordsville	J. M. Kirtley, Crawfordsville
MORGAN (1)	
E. T. Drake, Martinsville	O. R. Wilson, Morgantown
NEWTON (1)	
R. S. Yegerlehner, Kentland	John Parker, Goodland
NOBLE (1)	
Robert Bryan, Kendallville	Carl Stallman, Kendallville
ORANGE (1)	
P. T. Hodgin, Orleans	
OWEN-MONROE (2)	
J. A. Creek, Bloomington	Harold Manifold, Bloomington
Roger Roof, Spencer	Thomas Skrentny, Spencer
PARKE-VERMILLION (2)	
PERRY (1)	
Fred Smith, Tell City	

County and Delegates	Alternates
PIKE (1)	
Milton H. Omstead, Petersburg	
PORTER (1)	
Jack E. Dittmer, Valparaiso	Paul C. F. Vietzke, Valparaiso
POSEY (1)	
L. John Vogel, Mt. Vernon	John Crist, Mt. Vernon
PULASKI (1)	
William R. Thompson, Winamac	
PUTNAM (1)	
Frederick Dettloff, Greencastle	John Ellett, Coatesville
RANDOLPH (1)	
Lowell Painter, Winchester	David J. Landon, Union City
RIPLEY (1)	
Bill Freeland, Batesville	
RUSH (1)	
Frank H. Green, Rushville	Stephen Smith, Knightstown
ST. JOSEPH (5)	
L. F. Sandock, South Bend	W. J. Stogdill, South Bend
W. Robert Orr, Mishawaka	R. A. Ganser, Mishawaka
Raymond E. Nelson, South Bend	George D. Colip, Notre Dame
Jacob Rosenwasser, Mishawaka	Herbert Schiller, South Bend
S. E. Bechtold, South Bend	George M. Haley, South Bend
SCOTT (1)	
Marvin McClain, Scottsburg	Thomas A. Neathamer, Scottsburg
SHELBY (1)	
Wilson L. Dalton, Shelbyville	John A. Davis, Flat Rock
SPENCER (1)	
John C. Glackman, Jr., Rockport	Michael O. Monar, Rockport
STARKE (1)	
Guy B. Ingwell, Knox	Clark McClure, Knox
STEUBEN (1)	
Donald G. Mason, Angola	

County and Delegates	Alternates
SULLIVAN (1)	
Betty Dukes, Dugger	J. H. Crowder, Sullivan
TIPPECANOE (2)	
R. B. DuBois, Lafayette	W. R. Van Den Bosch, Lafayette
F. J. Babb, Stockwell	W. E. Bailey, Lafayette
TIPTON (1)	
A. E. Stouder, Kempton	M. B. Gossard, Tipton
VANDERBURGH (5)	
Ray H. Burnikel, Evansville	William C. Grimm, Evansville
J. Guy Hoover, Evansville	Robert Oswald, Evansville
Charles M. Sinn, Evansville	James Mathews, Evansville
George W. Willison, Evansville	Albert Ritz, Evansville
John D. Wilson, Evansville	Ralph E. Zwickel, Evansville
VIGO (2)	
William G. Bannon, Terre Haute	
Thomas J. Conway, Terre Haute	
WABASH (1)	
F. C. Poehler, LaFontaine	
WARRICK (1)	
Wendell C. Stover, Boonville	
WASHINGTON (1)	
T. K. Tower, Campbellsburg	E. R. Apple, Salem
WAYNE-UNION (2)	
Glen Ward Lee, Richmond	Tom Shields, Richmond
Clarence G. Clarkson, Liberty	Frank Lewis, Liberty
WELLS (1)	
Truman E. Caylor, Bluffton	Charles E. Boonstra, Bluffton
WHITE (1)	
W. Martin Dickerson, Monticello	Nolan A. Hibner, Monticello
WHITLEY (1)	
Thomas Hamilton, Columbia City	Frank Thompson, Columbia City

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W. U. Kennedy, New Castle
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Executive Secretary—James A. Waggener, Indianapolis

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2nd District—E. T. Edwards, Vincennes
3rd District—Donald M. Kerr, Bedford
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5th District—V. Earle Wiseman, Greencastle
6th District—William R. Tindall, Shelbyville
7th District—Albert M. Donato, Indianapolis
8th District—Donald R. Taylor, Muncie
9th District—Peter R. Petrich, Attica
10th District—Lowell H. Steen, Whiting
11th District—Lowell J. Hillis, Logansport
12th District—Milton F. Popp, Fort Wayne
13th District—Otis R. Bowen, Bremen

AMA DELEGATES

Harold C. Ochsner, Indianapolis
E. S. Jones, Hammond
Guy A. Owsley, Hartford City
Jack E. Shields, Brownstown

Fifty-Year Club-1966

ALLEN COUNTY
Lynn W. Elston, Fort Wayne

ELKHART COUNTY
Melvin S. Teters, Middlebury

HENRY COUNTY
William C. Heilman, Sr., New Castle

KNOX COUNTY
Guy H. Wilson, Bicknell

LAKE COUNTY
Eli S. (Jack) Jones, Hammond
Christ M. Stoycoff, Gary

LAPORTE COUNTY
Russell A. Gilmore, Michigan City

MARION COUNTY
William E. Arbuckle, Indianapolis
Kenneth L. Craft, Indianapolis
Earl H. Hare, Indianapolis
Edwin N. Kime, Bloomington
Jacob Paskind, Indianapolis (deceased)
John H. Warvel, Sr., Indianapolis

MIAMI COUNTY
Stephen D. Malouf, Peru

ST. JOSEPH COUNTY
Milo K. Miller, South Bend

VANDERBURGH COUNTY
John W. Visher, Evansville

WASHINGTON COUNTY
Irvin E. Huckleberry, Salem

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Noel Graves, Vevay, (Jefferson-Switzerland)
John C. Glackman, Jr., Rockport (Spencer)
Edward D. Miller, Fort Wayne (Allen)

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Donald L. McKinney, Otterbein (Benton)
Joseph L. Haymond, Indianapolis (Marion)
Kenneth R. Ockermann, Rensselaer (Jasper)

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Raymond E. Nelson, South Bend (St. Joseph)
Thomas M. Brown, Muncie (Delaware-Blackford)
John D. Wilson, Evansville (Vanderburgh)
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Ray H. Burnikel, Evansville (Vanderburgh)
Wallace R. Van Den Bosch, Lafayette (Tippecanoe)

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S. E. Bechtold, South Bend (St. Joseph)
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Ramon B. DuBois, Lafayette (Tippecanoe)
L. John Vogel, Mt. Vernon (Posey)

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Thomas J. Conway, Terre Haute (Vigo)

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Malcolm O. Scamahorn, Pittsboro (Hendricks), *Chairman*
Burton E. Kintner, Elkhart (Elkhart)
J. S. Farquhar, Fort Wayne (Allen)
Charles E. Test, Indianapolis (Marion)
William G. Bannon, Terre Haute (Vigo)

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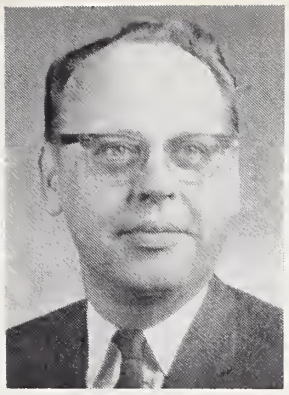
Max Hoffman, Covington (Fountain-Warren)
Fred Smith, Jr., Tell City (Perry)
Thomas E. Lunsford, Indianapolis (Marion)
Bill Freeland, Batesville (Ripley)

1965-1966
Officers of the ISMA

KENNETH O. NEUMANN, M.D.
President
Indiana State Medical Association
1965-66



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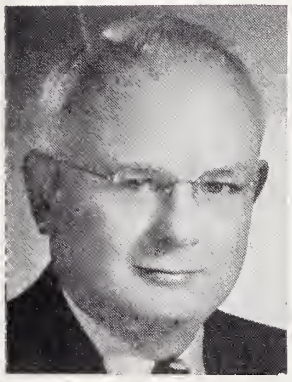
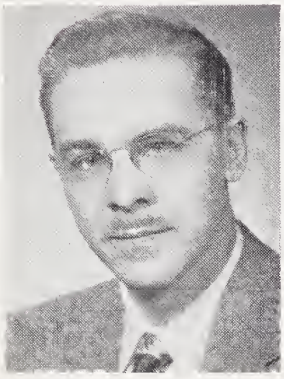
President-Elect
Van Buren

OTTIS N. OLVEY, M.D.
Treasurer
Indianapolis

E. T. EDWARDS, M.D.
Chairman of Council
Vincennes



RALPH V. EVERLY, M.D.
Chairman
Executive Committee
Indianapolis



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Asst. Treasurer
Indianapolis

G. O. LARSON, M.D.
Executive Committee
LaPorte

MAZO D. SCALES
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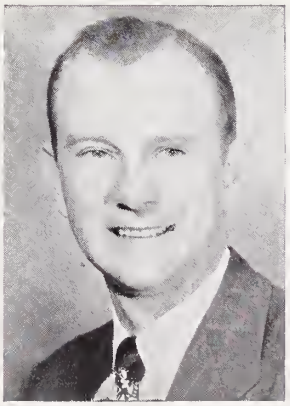
Huntingburg

JAMES A. WAGGENER
Executive Secretary
Indianapolis

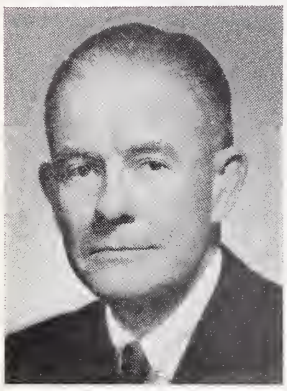
KENNETH W. BUSH
Administrative Assistant
Indianapolis



ROBERT J. AMICK
Field Secretary
Scottsburg

HOWARD GRINDSTAFF
Field Secretary
Indianapolis

The Journal



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Editor
Indianapolis

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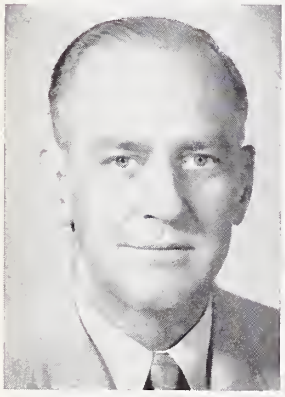
Associate Editor
Terre Haute

L. G. MONTGOMERY, M.D.
Associate Editor
Muncie

DAVID A. BICKEL, M.D.
Associate Editor
South Bend



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Editorial Board
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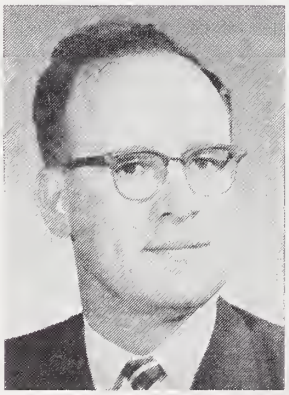
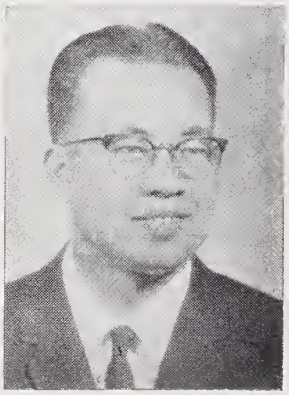
Editorial Board
Evansville

JENE R. BENNETT, M.D.
Editorial Board
South Bend



ALVIN J. HALEY, M.D.
Editorial Board
Fort Wayne

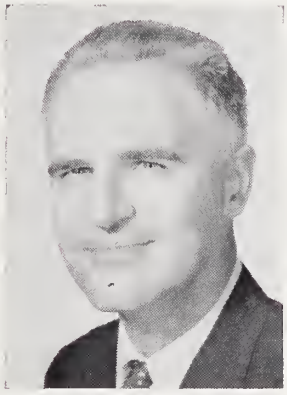


WEI-PING LOH, M.D.
Editorial Board
Gary

Section Officers

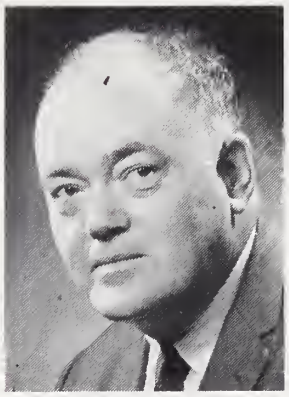
Surgery

CHAIRMEN



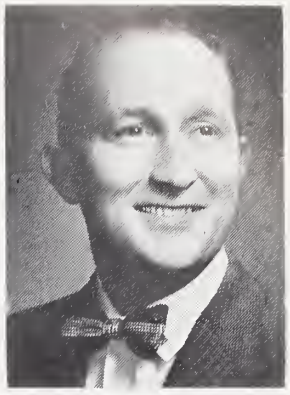
DONALD W. MEIER, M.D.
Bluffton

VICE-CHAIRMEN



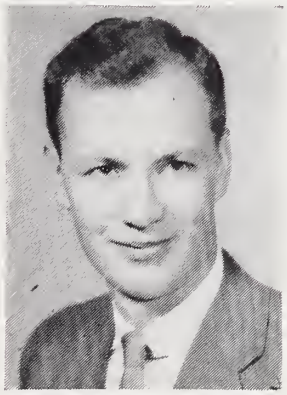
JOSEPH C. FINNERAN, M.D.
Indianapolis

SECRETARIES

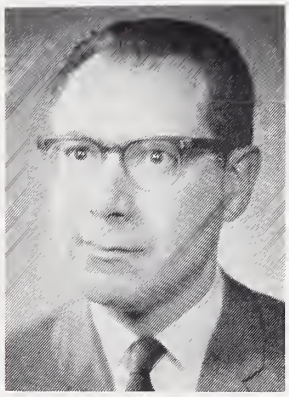


DONALD M. SCHLEGEL, M.D.
Indianapolis

Internal Medicine



CHARLES M. SINN, M.D.
Evansville



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ROBERT L. RUDESILL, M.D.
Indianapolis

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LEWIS E. MORRISON, M.D.
Indianapolis

M. RICHARD HARDING, M.D.
Indianapolis

GEORGE A. CLARK, M.D.
Indianapolis

Anesthesiology

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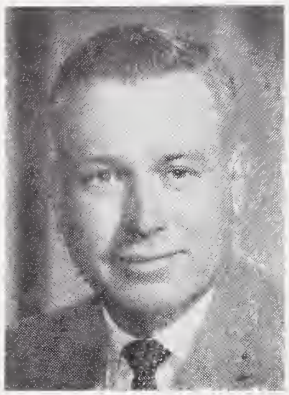
RICHARD H. STEIN, M.D.
Vincennes

VICE-CHAIRMEN

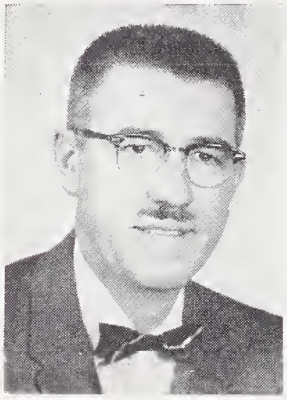


EUGENE SCHMIDT, M.D.
Fort Wayne

SECRETARIES

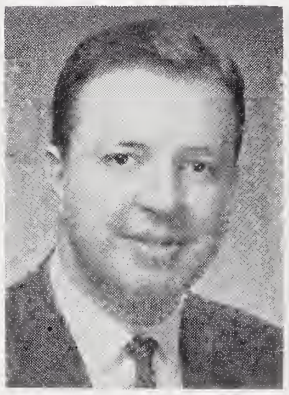
WILLIAM M. MATTHEWS, M.D.
Indianapolis

General Practice



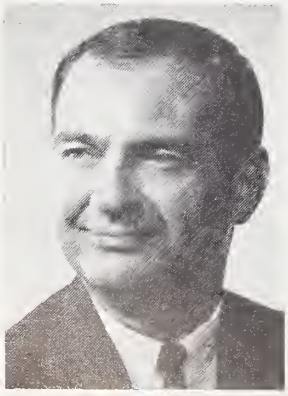
FORREST BABB, M.D.
Stockwell

ROSS L. EGGER, M.D.
Middletown



JAY S. REESE, M.D.
Martinsville

Obstetrics and Gynecology



FRANK C. DONALDSON, M.D.
Anderson

JOSEPH F. THOMPSON, M.D.
Indianapolis

ROBERT M. REID, M.D.
Columbus

Public Health and Preventive Medicine

CHAIRMEN

PHILIP J. ROSENBLOOM, M.D.
Gary

VICE-CHAIRMEN

NO PICTURE AVAILABLE

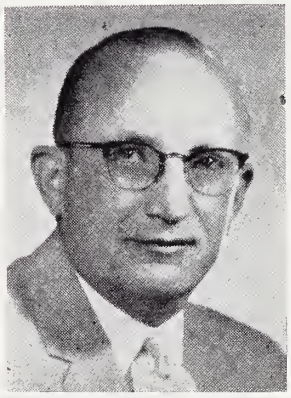
DONALD M. KERR, M.D.
Bedford

SECRETARIES

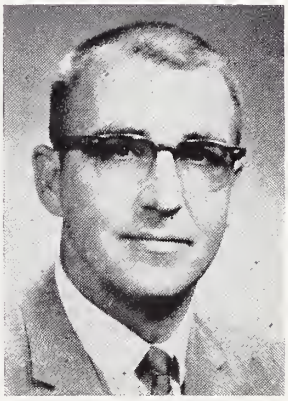
HENRY G. NESTER, M.D.
Indianapolis

Radiology

LOUIS C. BIXLER, M.D.
South Bend

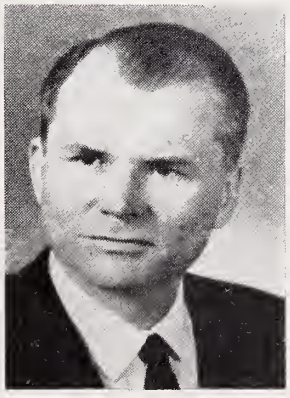


WILLIAM J. STANGLE, M.D.
Bloomington



RICHARD A. SILVER, M.D.
Indianapolis

Nervous and Mental Diseases



DEWITT W. BROWN, M.D.
Indianapolis

LESTER D. BOROUGH, M.D.
South Bend

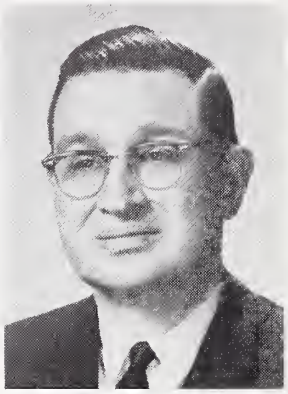
GENE E. LYNN, M.D.
Indianapolis

Pathology

CHAIRMEN

CHARLES E. BOONSTRA, M.D.
Bluffton

VICE-CHAIRMEN

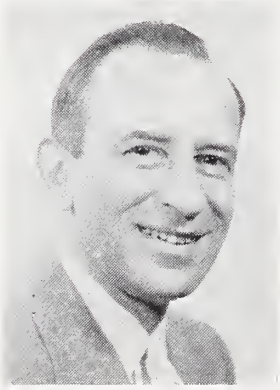


JOSEPH HAYMOND, M.D.
Indianapolis

SECRETARIES

ROBERT L. COSTIN, M.D.
Indianapolis

Pediatrics



ROLAND E. MILLER, M.D.
Lafayette

GUSTAF W. ERICKSON, M.D.
South Bend

MORRIS GREEN, M.D.
Indianapolis

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Schedule of Events

117th Annual Convention
Indiana State Medical Association
French Lick-Sheraton Hotel
French Lick, Indiana
October 10, 11, 12 and 13, 1966

(All Events on Eastern Standard Time)
(The scientific program of the 117th annual convention of the Indiana State Medical Association is acceptable for 13 accredited hours by the American Academy of General Practice.)

Sunday, October 9, 1966

7:00 p.m. Executive Committee dinner meeting, Mural Room.

Monday Morning, October 10, 1966

8:00 a.m. Council breakfast meeting, Terrace Room.

9:00 a.m. Registration begins, Convention Hall.

9:00 a.m. Opening of technical and scientific exhibits, Convention Hall.

10:00 a.m. Annual golf tournament. Eighteen holes, low gross, bankers' handicap and blind bogie medal play. French Lick Hill Course.

11:00 a.m. Editorial Board meeting, Mural Room. Luncheon at 12.

11:00 a.m. Annual trap-skeet shoot, French Lick Trap and Skeet Club.

11:00 a.m. to 2:30 p.m. Time allowed to view technical and scientific exhibits, Convention Hall.

Monday Noon, October 10, 1966

12 noon Luncheon meeting of Past Presidents of the Indiana State Medical Association, Roost Room.

Monday Afternoon, October 10, 1966

2:00 p.m Meeting of House of Delegates, North Convention Hall.

4:30 p.m. to 5:00 p.m. Time allowed to view technical and scientific exhibits, Convention Hall.

Monday Evening, October 10, 1966

6:00 p.m. Supper, smoker and stag party, main dining room.
Presentation of sports trophies.

6:00 p.m. Women physicians' dinner meeting, Terrace Room.
Speakers:
VIRGINIA W. LIVINGSTON, M.D., San Diego, Calif.
ELEANOR ALEXANDER-JACKSON, Ph.D., New York, N. Y.

VIRGINIA WUERTHELE-CASPE LIVINGSTON, M.D.
La Jolla, Calif.
Formerly Assistant Professor of Microbiology, Rutgers University; Specialist in internal medicine, oncology bacteriological medicine; M.D. degree from the New York University Bellevue Medical School, 1936.

ELEANOR ALEXANDER-JACKSON, Ph.D.
New York, New York
Consultant to physicians on microbiological problems; Specialist in pathogenic mycobacteria and mycoplasma associated with degenerative and neoplastic diseases; First woman to win the A. Cressy Morrison Prize of the New York Academy of Sciences for her work with the tubercle bacillus.

Fireside Conferences
on
CARDIO-RESPIRATORY DISEASES

Monday, October 10, 1966, 8:00 P.M.
(Open to all Physicians)
Roost Room, Mezzanine Floor
French Lick, Indiana

SPONSORED BY THE INDIANA STATE MEDICAL ASSOCIATION AND THE INDIANA CHAPTER OF THE AMERICAN COLLEGE OF CHEST PHYSICIANS.

This is an annual feature of the Indiana State Medical Convention. The conferences are informal and unrehearsed, providing an opportunity for free discussion of many subjects of interest to general practitioners and specialists alike. A panel of experts will be seated at each of eight tables, and physicians are encouraged to ask questions, express their own ideas, and comment on the various problems under discussion. They may move from one table to another if and when they wish.

1. *Cardiac Monitoring, Resuscitation and Pacemakers*

   JOHN V. THOMPSON, M.D., Moderator, Indianapolis
   RICHARD H. JOWITT, M.D., Indianapolis
   FRED M. KUIPERS, M.D., Lafayette

2. *Emphysema*

   DONALD F. MacLEOD, M.D., Moderator, West Lafayette
   GEORGE BUCKNER, M.D., Fort Wayne
   RICHARD MATZEN, M.D., Bluffton
   RAMON S. DUNKIN, M.D., Indianapolis

3. *Coronary Insufficiency*

   A. D. DENNISON, JR., M.D., Moderator, Indianapolis
   ALBERT L. BLAKE, M.D., Indianapolis
   HAROLD F. BURDETTE, M.D., Indianapolis
   E. PAUL TISCHER, M.D., Indianapolis

4. *Atypical Pulmonary Infections*

   ARVINE G. POPPLEWELL, M.D., Moderator, Indianapolis
   RICHARD S. GRIFFITH, M.D., Indianapolis
   NORMAN K. WILSON, M.D., Crown Point
   JOSEPH BRICKLER, bacteriologist, Indianapolis

5. *Use and Abuse of Digitalis*

   CHARLES FISCH, M.D., Moderator, Indianapolis
   J. HAL DORAN, M.D., Indianapolis
   JOHN BUTLER, M.D., Indianapolis

6. *Thoracic Injuries*

   HENRY LARZELERE, M.D., Moderator, Marion
   DONALD C. FIELDS, M.D., Lafayette
   WILLIAM JOSEPH MILLER, M.D., Lafayette

7. *Pediatric Chest Problems*

   JOHN MILLER, M.D., Moderator, Indianapolis
   ROBERT E. GERTH, M.D., Indianapolis
   PAUL KIRKHOFF, M.D., Indianapolis
   PAUL LURIE, M.D., Indianapolis

8. *Advances in Thoracic Surgery*

   J. STANLEY BATTERSBY, M.D., Indianapolis
   JOSEPH C. ROSS, M.D., Indianapolis
   HARRY SIDERYS, M.D., Indianapolis

Tuesday Morning, October 11, 1966

8:00 a.m.	Council breakfast meeting, Terrace Room.
9:00 a.m.	Registration continues, Convention Hall.
9:00 a.m.	Technical and scientific exhibits, Convention Hall.
9:00 a.m.	Reference Committees meet. Meeting rooms, basement, Convention Hall.
11:00 a.m. to 12 noon	Time allowed to view technical and scientific exhibits, Convention Hall.

Tuesday Noon, October 11, 1966

12 noon	Phi Rho Sigma luncheon, Mural Room.
12 noon	Phi Chi luncheon, Terrace Room.
12 noon	Phi Beta Pi luncheon, Sheraton Room.
12 noon	Nu Sigma Nu luncheon, Roost Room.
1:00 p.m.	Flying Physicians Association, Indiana Chapter, meeting, Room 227, mezzanine floor. (Not a luncheon meeting).

GENERAL MEETING

(North Convention Hall)

Call to order by Kenneth O. Neumann, M.D., Lafayette, President, Indiana State Medical Association.

Seminar on Immunization

ROLAND E. MILLER, M.D., Lafayette, State Chairman, Indiana Chapter of American Academy of Pediatrics, presiding.

1:30 p.m. *"Precautions and Complications of Immunization"*
SARAH H. SELL, M.D., Nashville, Tenn.

2:15 p.m. *"Use and Abuse of Gamma Globulin"*
LEWIS L. CORIELL, M.D., Camden, N. J.

2:50 p.m. to 3:20 p.m. Time allowed to view technical and scientific exhibits, Convention Hall.

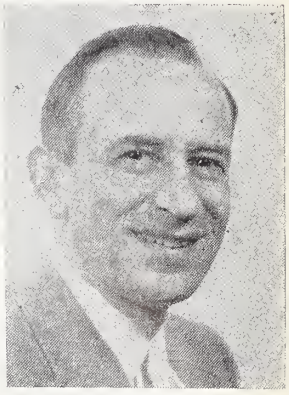
3:20 p.m. *"Measles Vaccines and Recent Advances in Rubella"*
PHILIP A. BRUNELL, M.D., New York, N. Y.

4:00 p.m. *"Polio Vaccines"*
LEWIS L. CORIELL, M.D., Camden, N. J.

4:30 p.m. *Panel Discussion* (Questions from the floor). Moderator:
ROLAND E. MILLER, M.D., Lafayette

Tuesday Evening, October 11, 1966

6:30 p.m. President's Night Dinner and Entertainment, main dining room. Featuring THE SINGING DOCTORS, a crackin' musical show by the members of the Greene County, Missouri, Medical Society.

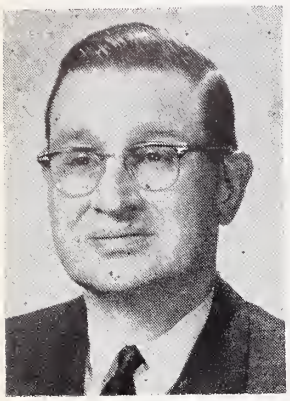


ROLAND E. MILLER, M.D.
Lafayette
State chairman of the Indiana Chapter of the American Academy of Pediatrics; Diplomate of the American Board of Pediatrics; M.D. degree from the Indiana University School of Medicine, 1940.

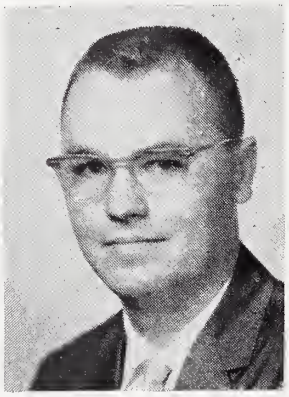
SARAH H. SELL, M.D.
Nashville, Tenn.
Assistant Professor of Pediatrics, Department of Pediatrics, Vanderbilt University Hospital, Nashville; Member of the Committee on Control of Infectious Diseases of the American Academy of Pediatrics; Board certified in pediatrics; M.D. degree from Vanderbilt University School of Medicine, 1948.

LEWIS L. CORIELL, M.D.
Camden, New Jersey
Professor, Department of Pediatrics, University of Pennsylvania Graduate School of Medicine; Director of Research of the South Jersey Medical Research Foundation; Senior physician, the Children's Hospital of Philadelphia; M.D. degree from the University of Kansas, 1942.

PHILIP A. BRUNELL, M.D.
New York, New York
Assistant Professor of Pediatrics, New York University Medical Center; Member of the Southern Society for Pediatrics Research; M.D. degree from the University of Buffalo School of Medicine, 1957.



JOSEPH L. HAYMOND, M.D.
Indianapolis
Director of the Thornton-Haymond-Costin Medical Laboratories, Indianapolis; Pathologist for the Hancock County Memorial Hospital, Rush Memorial Hospital, Riverview Memorial Hospital and W. S. Major Hospital; M.D. degree from the Indiana University School of Medicine, 1936.



TED S. DOLES, M.D.
Middletown
General practitioner, Middletown Medical Clinic; M.D. degree from the Indiana University School of Medicine, 1962.

TOMMY N. EVANS, M.D.
Detroit, Mich.
Professor and Chairman, Department of Obstetrics and Gynecology, Wayne State University School of Medicine; Consultant to Detroit General, Harper and Hutzel Hospitals, Detroit; M.D. degree from Vanderbilt University School of Medicine, 1945.

JOSEPH F. THOMPSON, M.D.
Indianapolis
Assistant Professor, Department of Obstetrics and Gynecology, Indiana University Medical Center; Specialist in obstetrics and gynecology; M.D. degree from the Indiana University School of Medicine, 1953.

Wednesday Morning, October 12, 1966

8:00 a.m. Council breakfast meeting. Terrace Room.

8:00 a.m. Small county delegates' breakfast meeting, West Dining Room.

9:00 a.m. Registration continues, Convention Hall.

9:00 a.m. Technical and scientific exhibits, Convention Hall.

9:00 a.m. to 11:00 a.m. Time allowed to view technical and scientific exhibits, Convention Hall.

Wednesday Noon, October 12, 1966

SECTION MEETINGS

11:00 a.m. to 2:00 p.m. Election of Section Officers for 1967.

11:00 a.m. SECTION ON GENERAL PRACTICE luncheon meeting, Parlors D and E

"A Laboratory in My Office?"
JOSEPH L. HAYMOND, M.D., Indianapolis
TED S. DOLES, M.D., Middletown

11:00 a.m. SECTION ON OBSTETRICS AND GYNECOLOGY luncheon meeting, Roost Room.

"Congenital Anomalies: Their Origin and Prevention"
TOMMY N. EVANS, M.D., Detroit, Mich.

11:30 a.m. *"Illegitimacy — A Growing Community Obstetrical Problem"*
JOSEPH F. THOMPSON, M.D., Indianapolis

Discussion by Dr. Evans

12 noon to 1:00 p.m. Luncheon and business meeting.

SECTION MEETINGS

Section on Obstetrics and Gynecology continues, Roost Room.

1:00 p.m. *"Diagnosis and Treatment of Recurrent Carcinoma of the Cervix"*
HANS E. GEISLER, M.D., Indianapolis

Discussion by Dr. Evans

1:30 p.m. *"Cervicitis and the Benefits of Cautery,"*
FRANK W. PEYTON, M.D., Lafayette

Discussion by Dr. Evans

11:00 a.m. SECTION ON NERVOUS AND MENTAL DISEASES, and Indiana Neuropsychiatric Association joint luncheon meeting, Hoosier Jr. Room.

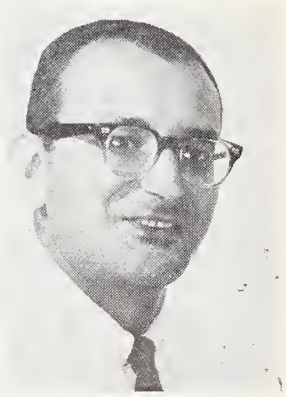
"Recent Experiences with Group Therapy,"
JOHN P. BELL, M.D., Louisville, Ky.

11:00 a.m. SECTION ON PATHOLOGY and Indiana Association of Pathologists joint luncheon meeting, Sheraton Room.

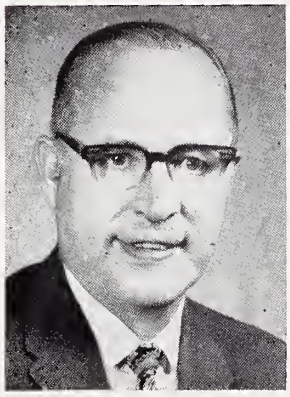
"Automation in Your Pathologist's Laboratory; Panel Testing, Costs, and Desirability"
MALCOLM L. BARNES, M.D., Louisville, Ky.

12 noon SECTION ON SURGERY and Indiana Chapter, American College of Surgeons joint luncheon meeting, Parlor G.

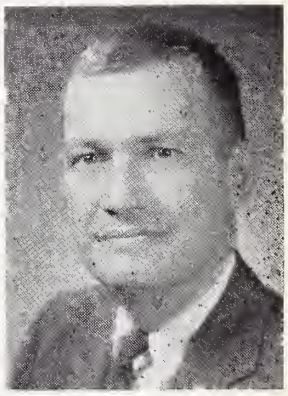
"Surgical Aspect of the Ileal Bypass as an Aid in Controlling Obesity"
MANRICO A. TRONCELLITI, M.D., Norristown, Pa.



HANS E. GEISLER, M.D.
Indianapolis
Assistant Professor of Obstetrics and Gynecology, Indiana University School of Medicine; Consultant to Methodist Hospital Gyn Tumor Clinic; Specialist in obstetrics, gynecology and gynecologic cancer; M.D. degree from Stritch School of Medicine, Loyola University, 1959.



FRANK W. PEYTON, M.D.
Lafayette
Specialist in obstetrics and gynecology, Woman's Clinic, Lafayette; Diplomate of the American Board of Obstetrics and Gynecology; Fellow of the American College of Obstetrics and Gynecology and the American College of Surgeons; M.D. degree from the University of Colorado School of Medicine, 1934.

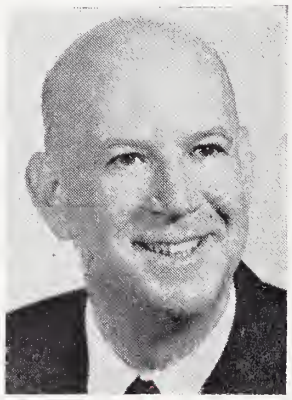


JOHN P. BELL, M.D.
Louisville, Ky.
Assistant Professor of Psychiatry, University of Louisville School of Medicine; Member of the staffs of Our Lady of Peace Hospital and Kentucky Baptist Hospital; Certified by the American Board of Neurology and Psychiatry; M.D. degree from Vanderbilt University School of Medicine, 1940.

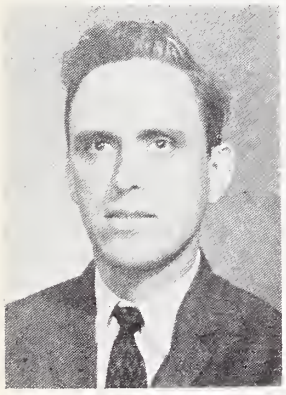
MANRICO A. TRONCELLITI, M.D.
Norristown, Pa.
Director of Surgery, Norristown State Hospital, Norristown; Attending Surgeon, Sacred Heart Hospital, Norristown; Formerly taught at the University of Pennsylvania Medical School and Women's Medical College, Philadelphia; general surgeon; M.D. degree from the University of Pennsylvania Medical School, 1941.

MALCOLM L. BARNES, M.D.
Louisville, Ky.
Associate Professor of Pathology, University of Louisville School of Medicine; Consultant to Louisville General Hospital, VA Hospital, Kosair Crippled Children's Hospital, Louisville, Ky., and Hardin County Memorial Hospital, Elizabethtown, Ky.; M.D. degree from the University of Louisville School of Medicine, 1935.

JOHN W. FROST, M.D.
Philadelphia, Pa.
Professor of Medicine, University of Pennsylvania; Director of the Department of Medicine, Pennsylvania Hospital; M.D. degree from the University of Pennsylvania School of Medicine, 1944.



IRVING ROSENBAUM, JR., M.D.
Indianapolis
Assistant Professor of Pediatrics, Indiana University School of Medicine; Lecturer, I.U. School of Social Work; Consultant to the Child Development Clinic, Riley Hospital, Indianapolis; M.D. degree from Johns Hopkins University, 1935.



EUGENE C. KLATTE, M.D.
Nashville, Tenn.
Professor and chairman, Department of Radiology, Vanderbilt University School of Medicine, Nashville; Consultant to the VA Hospital and the Nashville General Hospital; Specialist in radiology; M.D. degree from Indiana University School of Medicine, 1952.

THE EXHIBITS

We urge you to visit with the exhibitors — they are here to help you —and to bring you the latest information. They contribute to financing your convention.

Wednesday Noon, October 12, 1966

SECTION MEETINGS

12 noon — SECTION ON INTERNAL MEDICINE and Indiana Society of Internal Medicine joint luncheon meeting, Parlor C.
"Implications of Splenomegaly,"
JOHN W. FROST, M.D., Philadelphia, Pa.

12 noon — SECTION ON PUBLIC HEALTH AND PREVENTIVE MEDICINE luncheon meeting, Parlor A.
"Family Planning in Public Health"
IRVING ROSENBAUM, JR., M.D., Indianapolis

12 noon — SECTION ON RADIOLOGY and Indiana Roentgen Society joint luncheon meeting, Terrace Room.

Speaker:
EUGENE C. KLATTE, M.D., Nashville, Tenn.

SECTION ON OPHTHALMOLOGY AND OTOLARYNGOLOGY
No meeting scheduled during ISMA convention.

SECTION ON ANESTHESIOLOGY
No meeting during ISMA convention due to conflict with national meeting in Philadelphia.

12 noon — Reception and luncheon for members of Fifty-Year Club, Mural Room.

Wednesday Afternoon, October 12, 1966

2:00 p.m. to 2:30 p.m. — Time allowed to view technical and scientific exhibits, Convention Hall.

GENERAL MEETING
(North Convention Hall)

Kenneth O. Neumann, M.D., Lafayette, president, Indiana State Medical Association, chairman

2:30 p.m. — *"Vascular Radiology"*
EUGENE C. KLATTE, M.D., Nashville, Tenn.

2:50 p.m. — Questions

Wednesday Noon, October 12, 1966

GENERAL MEETING continues

3:00 p.m. *"Diagnosis and Treatment of Dysfunctional Uterine Bleeding"*
TOMMY N. EVANS, M.D., Detroit, Mich.

3:20 p.m. Questions

3:30 p.m. *"Your Friendly Corner Medical Laboratory: How Useful Can It Be?"*
MALCOLM L. BARNES, M.D., Louisville, Ky.

3:50 p.m. Questions

4:00 p.m. *"Jejunoileostomy, Jejunocolostomy in the Treatment of Intractable, Exogenous Obesity"*
MANRICO A. TRONCELLITI, M.D., Norristown, Pa.

4:20 p.m. Questions

4:30 p.m. *"Sexual Behavior,"*
JOHN P. BELL, M.D., Louisville, Ky.

4:50 p.m. Questions

Wednesday Evening, October 12, 1966

6:00 p.m. President's reception, formal gardens.

7:15 p.m. Annual dinner, main dining room.
Presiding officer:
KENNETH O. NEUMANN, M.D., President, Indiana State Medical Association.

Invocation.

Recognition of Fifty-Year Club members.

Presentation of plaque to KENNETH O. NEUMANN, M.D., Lafayette, president. 1966, by EUGENE S. RIFNER, M.D., Van Buren, president, 1967.

Thursday Morning, October 13, 1966

8:30 a.m. Final meeting of House of Delegates, West Dining Room, (breakfast meeting).

Meetings of Council and Executive Committee immediately following adjournment of House of Delegates.

Auxiliary Program

Mrs. Thomas H. Gootee, Jasper, and
Mrs. Francis H. Gootee, Jasper, co-chairmen

Monday, October 10, 1966

9:00 a.m. Registration begins, Convention Hall.

6:00 p.m. Does' Dinner, west dining room (complementing the stag supper).
Mrs. Alfred B. Scales, president, presiding

Tuesday, October 11, 1966

9:00 a.m. Registration continues, Convention Hall.

10:00 a.m. Golf tournament, French Lick Valley Course.
Mrs. Edwin R. Eaton, Indianapolis, chairman

2:00 p.m. Bridge and Canasta, Porch, French Lick-Sheraton Hotel

6:30 p.m. Dinner and entertainment in conjunction with Indiana State Medical Association, main dining room.

Wednesday, October 12, 1966

8:00 a.m. Executive Committee breakfast meeting, Mural Room.

9:00 a.m. Registration continues, Convention Hall.

10:00 a.m. Board meeting and first session of Annual Workshop, North Convention Hall. ("Early Bird" prizes).

12 noon Wooden Nickel luncheon, west dining room. (Door prizes).

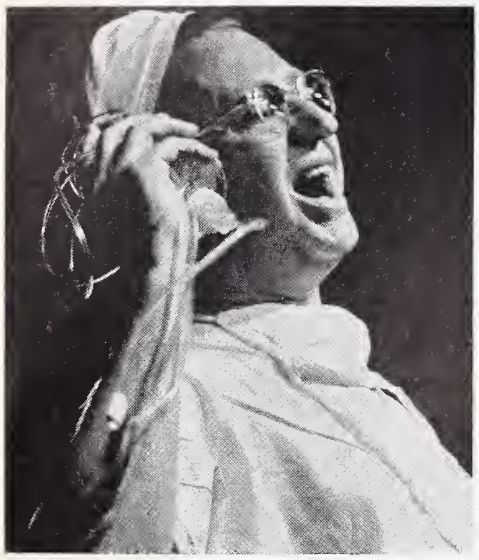
1:30 p.m. Workshop continued, mezzanine floor. ("Early Bird" prizes).

2:30 p.m. Buzz session.

3:30 p.m. Adjournment.

7:15 p.m. Annual dinner in conjunction with the Indiana State Medical Association, main dining room.

Convention Arrangements Committees



DR. CHARLES E. LOCKHART, shown here singing of a "negative appendectomy," is the Singing Doctors' only trained voice. The balance of the group, according to Dr. Jim Brown, is a "bunch of hammy extroverts who border on being tone deaf." The group will entertain at the President's Night Dinner Tuesday evening in the main dining room.

GENERAL CONVENTION ARRANGEMENTS: Francis E. Stout, Muncie, chairman; Richard B. Hovda, Evansville, vice-chairman; Durward W. Paris, Kokomo, secretary; Clarence R. McIntire, Bloomington; Irvin Sonne, New Albany; Merritt O. Alcorn, Madison; John E. Freed, Jr., Terre Haute; John Mader, Richmond; William M. Kendrick, Mooresville; Boyd A. Burkhardt, Tipton; John L. Ferry, Whiting; Charles H. Aust, Fort Wayne; James D. Finfrock, Elkhart; Kenneth Kohlstaedt, Indianapolis; Charles Fisch, Indianapolis.

ENTERTAINMENT: William M. Kendrick, Mooresville

SCIENTIFIC EXHIBITS: Richard B. Hovda, Evansville

WOMEN PHYSICIANS: Betty Dukes, Dugger

WOMEN'S ENTERTAINMENT: Mrs. Thomas H. Gootee, Jasper, and Mrs. Francis H. Gootee, Jasper, co-chairmen

MEN'S GOLF TOURNAMENT: Boyd A. Burkhardt, Tipton

WOMEN'S GOLF TOURNAMENT: Mrs. Edwin R. Eaton, Indianapolis

TRAP-SKEET SHOOT: Claude M. Donahue, Carmel

ART AND HOBBY SHOW: Charles P. Schneider, Evansville, and Ray H. Burnikel, Evansville, co-chairmen

THE SINGING DOCTORS

Melodies such as "Hemorrhoids," "Halitosis Beats No Breath at All," "Pass'a No Gas," "Black and Blue Cross" and "Pentothal is a Ball" may not be on the current hit parade, but they bring smiles to the faces of professional men who hear the Greene County (Missouri) Medical Society's performing physicians sing them.

"The Singing Doctors" will provide the entertainment at the President's Night Dinner Tuesday evening in the main dining room. The group's albums have netted over $110,000 in profits to provide 101 medical scholarship loans and grants. The albums, which contain over 40 hilarious ditties, sell for $9.75 for the complete set of three LP's, at the Society office, Medical Arts Building, Springfield, Missouri.

Lyrics for the shows were written by Drs. James T. Brown and Charles E. Lockhart. Members of the cast are (Left to right): surgeons F. T. H'Doubler, Jr., Don F. Gose, pathologist Fred Coller, surgeon James T. Brown (the group's leader-lyricist-emcee), internist Harold H. Lurie and surgeon Charles E. Lockhart. Accompanist for the group is Dr. Wilfred Adler.

YOUR CONVENTION OFFERS:

20 Scientific Exhibits

55 Technical Exhibits

Fireside Conferences

Section Meetings

50-Year Club Reception

Scientific Meetings

Reports of Officers

Executive Secretary

As you review the activities of the association, as outlined in the reports of the Executive Committee, the Council, the commissions and other committees, I am sure you will get a rather comprehensive picture of the activities carried on by your association during the past year.

Perhaps I should comment on a few specific items:

Membership

During the past 17 years, your association has shown a net growth in members of 636 which averages 37.4 new members per year with a total membership at the close of the year 1965 of 4,394 members. Five years ago the study made by the Department of Economics of Indiana University projected a need for 6,000 physicians by the year 1970. From 1950 through 1965, Indiana University has graduated 2,184 physicians, or an average of 136.5 per year. We have lost an average of 81+ members per year by death, so taking this as an average, we have been retaining an average of 118.4 physicians per year from those who graduate from the University or move to our state from other localities. The association, a few years ago, adopted a resolution calling upon the state of Indiana to study medical school requirements in this state. It appears that the 1967 legislature will have this matter squarely before it. It has been pointed out, however, by those who are knowledgeable on the subject, that ways must be found to encourage more physicians to locate their practice in Indiana if we are to meet the goal of 6,000 by the year 1970.

Building

The association has now occupied its own building for a period of four years and two months. It should be noted that of the original cost of the building, only $20,000.00 remains unpaid and it is the plan of your official bodies to retire this balance before the next convention. With the advent of the association building its own headquarters on the present site, the entire area between 38th and 40th streets is now occupied by apartments and buildings. The development of this area has seen an increase in frontage cost for ground quadrupled during this period. The association building now has buildings both on the immediate north and south. Future expansion is fast developing between 38th and 40th on the Pennsylvania Street side. Your Council, recognizing the time would come when additional space would be needed for your association, purchased the property adjacent to the east of the present property as a hedge for expansion and against future inflation prices in the Pennsylvania Street area.

The Building Committee has maintained your building in excellent condition during its four years of use and most visitors to the office for the first time are surprised to learn we have occupied the building for as long as we have.

Executive Committee and Council

Every member of this association should take recognition of the dedicated efforts of the men who serve you on these two important bodies of the association. This past year has brought extensive demands upon your officers time in resolving questions and matters which have far-reaching effects upon the future of medicine in this state and nation. I am sure that none, except those who are involved, have any conception of the great amount of time and personal sacrifices which have been made by those who represent you in their efforts to resolve the current problems of the day.

Commissions and Committees

Much can be said for the work being carried on by your commissions and other committees of the association and here again, we find a group of dedicated individuals who are willing to sacrifice their time to study the current problems and make recommendations of importance. I would urge you all to thoroughly review their activities as outlined in their reports.

Field Service

As one might well imagine, the field service has had a very active year in their attempt to keep component societies and individual members fully informed on the issues of the day. Our two field representatives, covering this entire state, traveled 38,641 miles this past year, visited 145 county society meetings and contacted 2,428 individuals. It is hoped that when the financial picture in the future is improved that the staff working with the component societies and individual members might be increased so that their work might be more effective and efficient.

Medicare

This past year this department has processed $408,592.07 in claims. We have been informed that the present Congress will implement, by January 1, 1967, an expanded program which will include outpatient care for members of active duty personnel; for rehabilitative care of children; also care for mentally retarded children of active personnel and for inclusion of retired active duty military and their families. The qualification for coverage under this program for the retired classification will be dependent upon their having served eight years in active duty. It is anticipated that this additional coverage will bring approximately 36,000 more people into the program nationally. No estimate can be made at this time as to what the increased load might be as far as Indiana is concerned but no doubt we shall share a proportionate number of these added people.

Headquarters Office

The work load in your association headquarters office has shown quite an increase during this past year and my thanks go to my loyal and devoted staff for carrying out the responsibilities which have been assigned to us. I want to express my personal appreciation to the officers, members of the commissions and committees for their untiring efforts in behalf of the association, also to the auxiliary for their many offers of help in carrying out the various expanded programs of your association.

JAS. A. WAGGENER, *Executive Secretary*

The Treasurer

The following is an itemized statement of the funds, including securities, of the association as of July 31, 1966.

Summary of all funds:

Fund	*Cash*	*Investments*	*Total*
General Fund	$ 9,772.45	$216,578.05	$226,350.50
Journal Fund	1,868.16	—	1,868.16
Medical Defense Fund	410.34	35,000.00	35,410.34
Building Fund	786.62	—	786.62
Building Fund (Auxiliary Donation)	3,777.71	—	3,777.71
Student Loan Fund (old)	669.53	9,000.00	9,669.53
Kitchen Fund	—	1,742.18	1,742.18
Total	$17,284.81	$262,320.23	$279,605.04

As of July 31, the income for the general fund has exceeded the budgeted estimate by $10,144.15. The expenditures for this period amount to $54,804.83 less than had been budgeted, however, we still have two months to go on the present fiscal year and it would appear at this time that our income will be over our expenses. We have set aside $61,-823.80 as reserves for operating expenses in the first quarter of the 1967 fiscal year, and as of December 31, we will write a check to the American Medical Education Research Foundation for $19,250.00.

The Executive Committee and the Council have regularly reviewed the investment portfolio of the association at each of their meetings and the treasurer has followed the recommendations of these bodies by investing all available cash in short term bills or in savings accounts in order to accumulate as much interest as possible for all the funds which were not required for current purposes. The certified audit of George S. Olive & Company for the fiscal year ending September 30, 1966 will not be completed in time for publication in this report. However, we believe 1966 will see a reversal of our previous trends in deficit spending and we will begin to equalize our expenses with our income. The final audit for the 1965 fiscal year was published in the December 1965 *Journal of the ISMA*, therefore we will not include it in this report.

As of July 31, our interest income from investments of surplus funds has amounted to $4,335.24. The balance of indebtedness on the building amounts to $20,000.00, which we hope will be entirely liquidated during this next fiscal year.

OTTIS N. OLVEY, M.D., *Treasurer*

Chairman of the Council

The detailed actions of the ISMA Council are reported in *The Journal* but a longitudinal view of the Council's deliberations may be helpful. The staggered terms of councilors give continuity to ISMA policy implementation and the six-year (two-term) limitation on councilor's service will provide "fresh blood," thus keeping the Council responsive to changing viewpoints of association members.

The work of the Council consists of directing the association's affairs during the interim between the annual House of Delegates meetings; therefore, it is concerned with problems affecting Indiana physicians as a group. But the Council is aware also of problems peculiar to individual physicians, county societies or particular areas of clinical practice.

As the Executive Committee of ISMA is the "housekeeping" body, it frequently is the first group to recognize fundamental issues, which it passes on to the Council. Its able chairman, Ralph Everly, M.D., is one of the unsung heroes of ISMA for in the past few years his personal guidance, wisdom, and time have been given beyond the routine call of duty. Perhaps the most significant action of the Executive Committee and the Council in the housekeeping realm this year was to acquire additional adjacent property for possible future growth of the headquarters area. If not used for expansion, this property is a tangible hedge against inflation for the association.

The Council also has a judicial responsibility. For the first time to our knowledge, it was called on this year to rule on an appeal to a county society's action in revoking membership of a physician for cause. The physician had the right of appeal to the Council and after two long Saturday night meetings, complete with attorneys for the physician, the county society and the ISMA attorney, it was the Council's decision to support the local society action. This was not a happy task for any of us concerned, yet the entire procedure represents the true ideals and spirit of a professional association.

As a component member of the AMA, the ISMA has five delegates and five alternate delegates elected by our House of Delegates. These AMA delegates represent all the physician members of our association. To better understand the views of physicians over the state on matters coming before the AMA, specially called meetings of the Council with AMA delegates have been held during the past two years prior to AMA meetings. The councilors are able to present to the delegates the thinking of physicians in their respective districts on various issues. Thus each physician member of ISMA and AMA has a direct route of communications for his views to the top level of organized medicine. Speaking for the Council and AMA delegates, we welcome your suggestions and/or criticisms. These meetings are usually held about two weeks before the AMA meetings, so don't wait too long to speak to your councilor.

Although the subject was mentioned only briefly this year, the problem of equal representation in the Council was introduced. Indiana has large metropolitan areas with large physician concentrations which results in a disproportionate representation. The rural areas with smaller physician population have relatively more Council representation per doctor. There are many facets to this situation which must be studied before any changes are recommended in Council structure.

Many guests appear before Council meetings. We are always happy to hear from Dr. Andrew Offutt, Commissioner of Health of Indiana, and Dr. Glenn Irwin, Dean of the Indiana University School of Medicine. Few states can claim as friendly and as effective working relationship as Indiana docs between organized medicine, the medical school and State Board of Health. Of course, it has been an advantage to have Lester Bibler, M.D., a member of the AMA Board of Trustees, attend Council meetings. While approving the I.U. Medical School's proposal to disperse medical education over the state, the Council welcomed study of possible new medical schools in Indiana without attempting to designate a particular site or make a specific recommendation as to advisability of a second school.

Dr. Frank Ramsey, Editor of *The Journal*, is another faithful participant in our meetings. Under his direction, we have an outstanding state medical journal for which he and it have gained national recognition. Perhaps other guests representing related medical service activities might find it worthwhile to attend occasional Council meetings. I am thinking of the chairman of the Indiana Board of Medical Registration and Licensure and the president of Blue Shield particularly.

Last year Congress drastically changed the financing of medical care in this country with the specification that PL 89-97 would not interfere with the patient-physician relationship or the actual clinical practice of medicine. Regulations since written by H.E.W., with the advice and frequent dissent of organized medicine, have the effect of law when printed in the Federal Register. These regulations are still being added after the July 1, 1966 initiation of the program.

The Council, Executive Committee, and AMA delegation have recognized the dangers in the basic law and the efforts and intent of those writing the regulations. The joint action of these officers of the association in cooperation with specialty organizations has been directed towards maintaining our present high level of patient care and intellectual and economic freedom for physicians. In doing this, we run the risk of appearing to be acting against our patients when actually we are trying to protect our patients from those persons attempting to federalize medical practice in this country.

Last year the Council approved the concept of usual and customary fees; the AMA delegates from Indiana introduced and won AMA approval for this basis of physician remuneration for all governmental financing of medical programs. Direct billing under PL 89-97 has been recommended to physicians by the Council as the only certain method for physicians to individually maintain control over their own fees. On April 17, 1966 a statewide meeting was held in Indianapolis to acquaint all Indiana physicians with Medicare provisions and implications as we understood them at that time. Dr. Albert Donato

has been the capable chairman of the Council's Committee on Medicare.

Both ISMA and Indiana Blue Shield submitted applications to act as carrier for Medicare. Blue Shield has the contract to be the fiscal agent. The Council approved both applications on the premise that it would be better for organized medicine to have some influence in this portion of the Medicare program. On the other hand, we must recognize that the carrier or "intermediary" is the agent of the government. There may be conflicts between governmental bureaucratic objectives and the interests of physicians, so it is probably better that ISMA does not have to wear two hats and can concentrate on representing physician and patient interests in any disputes.

Dr. Lowell Steen, chairman of the Council Liaison Committee with Blue Shield, has the responsibility of presenting ISMA views on various Blue Shield activities to the Blue Shield board. This committee will have even more importance in the future due to Blue Shield acting as a governmental contractor. The physician Blue Shield board members have the difficult assignment of representing the Blue Shield policyholders or members and also the practicing physicians in their districts. The distinction between the proper concern of Blue Shield and that of ISMA on many matters of joint interest is sometimes not too clear. An even closer relationship between these two organizations whose common basic aim is service to the public will be needed in the future.

Most physicians in Indiana practice fee-for-service and are not salaried. In varying degree, they are dependent upon hospital staff privileges. For these reasons, the Council has given much consideration and support to the plight of hospital-based specialists. The evident trend in federal legislation and regulations has been to create the position that these physicians are hospital employees which would establish a precedent for hospitals hiring the entire medical staff eventually. We have supported the national specialty proposals for separate billing and have attempted to further define the ethical considerations involved. Some success has been noted which may encourage continuing support for the private practice of medicine.

I wish to thank all the councilors and their alternates for their willingness to give their time and wisdom to the association during the past year. Greater demands are being placed on these men in terms of increased number of days away from their home and practice as well as the increased responsibility of decisions in these difficult times for medicine. Gratitude should likewise be expressed to you who "cover" for us while we are away from our patients. Of course, the Council could not function without the capable work of the executive secretary, his office staff and the field men. We appreciate their service.

E. T. EDWARDS, M.D., *Chairman*

First Councilor District

The annual meeting of the First District Medical Society was held Thursday, May 26, 1966 in Evansville in the Mead Johnson Hall of Deaconess Hospital. Preceding the dinner, the members and their wives were guests at a hospitality reception in the nearby Fireside Restaurant, with Mead Johnson & Company as host.

Following the dinner, brief reports were given by Dr. George W. Willison, director of Blue Shield, and Dr. Gilbert W. Wilhelmus of I-HOPE.

In the business meeting, Dr. Edward T. Edwards, chairman of the Council, spoke on topics of current and future activities of organized medicine.

Officers elected were: Dr. Wallace M. Adye, Jr., president, Dr. R. E. Weitzel, vice-president, and Dr. Milton H. Anderson, secretary-treasurer. Mr. Arthur P. Tiernan will continue as executive secretary.

On June 14, 1966, a meeting sponsored by the Vanderburgh County Society was attended by members from throughout the district at Deaconess Hospital. A symposium of six speakers, with Dr. Edgar L. Engel, chairman, gave a comprehensive discussion of Medicare, especially the operational aspects relating to the practicing physician.

The Vanderburgh County Medical Society and the medical auxiliary are already embarked on long-term planning for the annual meeting of the ISMA to be held in Evansville in 1970.

PATRICK J. V. CORCORAN, M.D., *Councilor*

Second Councilor District

The Second District met June 9, 1966, at the Elks Club, Washington, Indiana, with the following scientific program:

M. R. Schroeder, Jr., M.D., discussed "Diagnosis and Treatment of Problems of Unborn Fetus" in two parts — afternoon and evening.

Dr. Alex J. Steigman discussed "Newer Problems With Immunizations" in the afternoon and "Medicine in India" in the evening.

Dr. Edwards discussed "Medicare and How It Affects the Second District." The program was sponsored by AAGP in cooperation with Eli Lilly & Co.

Election of district president was deferred pending action of Greene County who will be host county at Linton in 1967. Dr. J. S. Brown, Carlisle, was re-elected secretary.

The councilor of the Second District wishes to thank his fellow councilors, officers, Executive Committee members and members of ISMA office staff for their cooperation and many kindnesses during his year as chairman of the Council. It has been an arduous period for all of us, with many special meetings, new Council sub-committees and difficult problems to resolve. These activities are reported in detail elsewhere in *The Journal*.

E. T. EDWARDS, M.D., *Councilor*

Third Councilor District

The Third District met at the French Lick Hotel on May 18, 1966, with Orange County as the host group and Dr. Marion Hagan presiding.

Guest speakers were: Dr. Thomas Marshal of the University of Louisville Department of Radiology, speaking on "Newer Diagnostic Aids in Radiology" and Dr. Glen Ley, internist of Bedford, speaking on "Pulmonary Function Studies and Emphysema."

Headquarters of Indiana State Medical Association was represented by Dr. E. T. Edwards, chairman of the Council, who discussed "Problems Relating to Medicare and Considerations of Future Probabilities to Follow the Present Problem."

The councilor discussed the problems of medicine, generally, and the district in particular in regard to the need for self-policing of *and* by our own members and urged increased efforts and improved methods.

The 1967 meeting will be held May 17, 1967 at the New Albany Country Club with Floyd County as host and Dr. Daniel Cannon as president of the district.

The major district problem of the year related to the appeal to the Council for reinstatement of membership in the county society after the society had voted to remove him from its rolls. This matter had been before the Council since prior to the last state meeting and was the first occasion in the history of the Council that such action had been taken. Special meetings of the Council were required to solve the problem and the Council found no grounds to rescind the action of the local society.

DONALD M. KERR, M.D., *Councilor*

Fifth Councilor District

The affairs of the Fifth District have gone on as usual for the past year except for the confusion of Medicare. The doctor-patient ratio has remained about the same. No serious complaints have come to the attention of the councilor.

The Fifth District meeting was held at the Clinton Country Club, June 8th. Dr. J. W. Somerville acted as chairman. At the business meeting, Wilbert McIntosh, M.D. was elected councilor. John Ellett, Jr., M.D., of Coatesville was elected president for the coming year; C. M. Schauwecker, M.D., Greencastle was elected vice-president; R. L. Veach, M.D. of Bainbridge was elected secretary-treasurer. The meeting was not well

attended due to conflicting meetings and vacations. A social hour was followed by a very good dinner.

The after-dinner speakers were E. T. Edwards, M.D., chairman of the Council who spoke on the subject of Medicare — its many facets and implications. Dr. William G. Bannon spoke in the interest of I-HOPE and the political responsibilities of the medical profession.

V. EARLE WISEMAN, M.D., *Councilor*

Sixth Councilor District

The Sixth District Medical Society held its annual meeting at the Shelbyville Elks Club, Wednesday, April 27, 1966, with the Shelby County Medical Society as host. Dr. Paul Inlow served at general chairman.

Golf was enjoyed by several doctors in the morning at the Elks Blue River Country Club.

The Indiana Academy of General Practice, in cooperation with Eli Lilly and Company, sponsored the educational seminar for the meeting. This scientific program was held in the afternoon and following dinner. Dr. J. H. Doran, internist, and Dr. R. E. Jenkins, dermatologist, both of Indianapolis, spoke on topics "Lung Scan — It's Use and Misuse in Diagnosis of Pulmonary Embolism and Pulmonary Tumors" and "Cutaneous Manifestations of Systemic Disease," respectively.

Following these discussions, a short business meeting was held, and the following officers were elected: Dr. Frank Green, Rushville, alternate councilor; Dr. John J. Farrell, Jr., Greenfield, president; Dr. Paul Inlow, Shelbyville, vice-president; Dr. Stephen D. Smith, Knightstown, secretary-treasurer.

Dinner was enjoyed at the Elks Town Club and the scientific meeting continued with Dr. Doran speaking on "A Critical Review of Anticoagulation" and Dr. Jenkins speaking on "Drug Eruptions."

During the afternoon the ladies of the medical auxiliary were entertained by a tour of Nelson's Studio and a talk by Mrs. Gerald Nelson on "Fashions in Flame." Committee members were Mrs. Paul Inlow, chairman, Mrs. Wilson Dalton, Mrs. Norman Richard and Mrs. William Green. Following dinner with their husbands, the ladies played bridge.

The Sixth District Meeting will be held in Rushville with Rush County as the host county in 1967. ◄

WILLIAM R. TINDALL, M.D., *Councilor*

Seventh Councilor District

Dr. Harry E. Mock, Jr., of Franklin, was elected president-elect of the Seventh District Medical Society at the annual meeting of the organization held June 15, 1966, in the Indiana State Teachers Association building in Indianapolis.

Dr. James H. Gosman, of Indianapolis, was re-elected secretary-treasurer of the society, and Dr. John O. Butler, of Indianapolis, was named alternate councilor. Dr. Glen V. Ryan, of Indianapolis, was elected director from the district on the Blue Shield board of directors.

Dr. Gosman, Dr. Ryan and Dr. Lester D. Bibler, of Indianapolis, a member of the Board of Trustees of the American Medical Association, spoke briefly.

Dr. Mock will succeed Dr. Jay S. Reese, of Martinsville, who assumed his duties at the meeting and who will serve until the 1967 annual meeting of the society.

ALBERT M. DONATO, M.D., *Councilor*

Eighth Councilor District

The Eighth District Medical Society met on June 1, 1966 at the Delaware County Club in Muncie. The Randolph County Medical Society served as the host group. A short business meeting was held under the direction of Dr. Lowell Painter, district president. Dr. Kenneth Neumann, president of the Indiana State Medical Association and Dr. Eugene Rifner, president-elect each spoke briefly on some of the problems anticipated after July 1 concerning Medicare.

Officers for 1967 were elected. Dr. Donald E. Spahr was named president and Dr. Joseph Vormohr was elected secretary-treasurer. Both are from Portland where the 1967 district meeting will be held on June 7, 1967.

Dr. Donald R. Taylor, of Muncie was re-elected for a second three-year-term as district councilor and Dr. Paul Sparks of Winchester was renamed as alternate councilor.

Many visiting physicians and wives enjoyed golf in the afternoon. A social hour and dinner followed the business meeting. Dr. Richard C. Bates of Lansing, Michigan was the dinner speaker.

DONALD R. TAYLOR, M.D., *Councilor*

Ninth Councilor District

The Ninth District this past year has been as confused and bemuddled as have you all concerning the many problems facing us in medicine.

The annual meeting at Fowler on May 19, 1966, brought out much discussion by interested members concerning our situation. We each know as much and as little as the rest about where we stand and where we are going. Needless to say, the immediate battle is well-lost but we still can fight to preserve the private practice of medicine. The way to do this is for each one to participate — participate with time, with money and with vocal exposition to patients, friends and civic groups. Don't wait to be asked to speak — speak for yourself and your colleagues at every opportunity.

We are attempting in our district to centralize our meeting locations for our annual meeting in order to attract and interest as many men as possible in attending and taking part in the business of organized medicine. An attempt will be made in this year to get agreement from all our component societies concerning several central meeting places to rotate the annual get-together, with each society hosting the meeting in order as before.

A special thanks to our alternate councilor, Dr. Clarence G. Kern, for organizing a fine meeting in the southern four-county area last fall. It was well attended and very stimulating. More regional meetings like this and more active county society meetings should be fostered and encouraged by the local groups. An organized front requires the coordination and cohesion of the many smaller units involved or to paraphrase the football coaches', "fight, men, fight."

PETER R. PETRICH, M.D., *Councilor*

Tenth Councilor District

The Tenth District held two well attended meetings during the past year. The first was on November 10, 1965. This meeting was attended by 120 doctors and wives. The president of the Tenth District Medical Society, Dr. Michael Shellhouse, opened the meeting by introducing the presidents of the county medical societies.

Dr. Shellhouse then presented Dr. Lowell H. Steen, councilor, who reported on the October meeting of the House of Delegates of the Indiana State Medical Association. He particularly emphasized the importance of the physicians reading all communications coming from the state association with respect to the mechanics of the new Medicare laws. He urged that doctors deal with their Medicare patients with respect to paying all fees directly, rather than by billing the government.

Dr. Herbert Arbeiter, member of the board of directors of I-HOPE, explained the activities of that organization and appealed for financial support for the important political activities of I-HOPE. Mr. Howard Grindstaff, field secretary for ISMA was introduced.

Dr. Shellhouse conducted a district election which resulted in the naming of Dr. Leslie Bombar as president and Dr. Louis Kudele as secretary.

Dr. Shellhouse then presented Dr. Glenn W. Irwin, Dean of Indiana University School of Medicine. Dr. Irwin described the medical education needs of Indiana, pointing out that although Indiana University is the largest medical school in the United States, it is the only school in the state and that, as a result, the number of new physicians prac-

ticing in Indiana is falling behind population changes. He described the requirements of the Indianapolis campus for improvement of its facilities, but stated that there was strong indication that a second school of medicine would have to be built in the near future.

He pointed out that half of the physicians presently graduating from the Indiana School of Medicine leave the state for internship and residencies, and never return. He also said that three-fourths of those who do stay, stay in Indianapolis. He said that the cost of a new school would be somewhere between $60 and $100,000,000, with total overall annual operating expenses of $25,000,000. He said that the faculty of the Indiana medical school was preparing a report, commenting on the Booz, Allen & Hamilton survey, for submission to the state legislature in February. He predicted that the faculty report would disagree with the survey recommendation that the Indianapolis campus be doubled in size. Both Dr. Irwin's formal presentation and his responses to questions were straightforward and well received by the society.

The second meeting was May 11, 1966. This meeting was attended by an overflow crowd of 180 physicians and wives. Dr. L. E. Bombar, president of the Tenth District Medical Society presided. During dinner, the minutes of the November district meeting were approved.

A resolution supporting the candidacy of Dr. E. T. Edwards for the office of president-elect of the Indiana State Medical Association was read, and a motion was made and adopted approving the sending of a letter to the ISMA officers and county medical societies supporting Dr. Edwards.

A motion was made and adopted, calling upon the Indiana state legislature to construct a school of medicine in northwestern Indiana.

Dr. Lowell H. Steen, Tenth District councilor, discussed the controversy concerning the employment of physicians by hospitals, with particular reference to the Medicare law. He urged the doctors to support the hospital-based physicians in their effort to establish their practices as independent private practices. A motion was made and adopted supporting this position.

Dr. Bombar conducted an election of Tenth District officers with the following results:

Alternate councilor to the ISMA — Dr. Herman Wing.

Member of the board of directors of Indiana Blue Shield — Dr. M. B. Gevirtz.

Dr. Bombar then introduced a panel to discuss various aspects of the coming Medicare laws:

Ernest B. Howard, M.D., Assistant Executive Vice-President, AMA, "Areas of Concern" — "Title 18."

Mr. Richard Kilborn, Executive Vice-President, Indiana Blue Shield, "Mechanics of Carrier."

Mr. Joseph Palmer, Medical Care Executive, Indiana State Board of Health, "Utilization and Post-Hospital Care."

Herman Wing, M.D., Member AMA Advisory Committee to HEW, "Hospital-based Physicians."

Eugene Rifner, M.D., President-Elect, ISMA, "Role of Individual Physicians."

Following the panel presentations, a lengthy session of questions and answers resulted in a considerable amount of information being provided.

LOWELL H. STEEN, M.D., *Councilor*

Twelfth Councilor District

The Wells County Medical Society was host for the annual meeting in Bluffton on May 18th and indeed they were gracious hosts. Dr. Warren Niccum presided at the business meeting and all officer and committee reports were accepted as presented. Dr. Eugene Rifner, Mr. James Waggener and Mr. Howard Grindstaff were present from the state association and Dr. Lowell Steen, Councilor of the Tenth District, again favored us with his presence. He's a mighty nice gentleman to have at a meeting.

Officers elected were Dr. Niccum re-elected as president, Dr. Fred Schoen re-elected as vice-president and Dr. Kenneth Isenogle re-elected as secretary-treasurer.

Following the social hour, dinner was served and the speaker of the evening was Dr. Amos Johnson, president of A.A.G.P. who discussed various aspects of Public Law 89-97 and more specifically the functions of the hospital utilization committee. There appeared to be a wide divergence of opinion on the latter subject and a rather heated question and answer session followed. One hundred eighteen were in attendance.

It has been a pleasure to have served as your councilor for another year and I want to thank all for very fine cooperation. Special thanks are due Dr. William R. Clark, alternate councilor, who has been most loyal and helpful.

MILTON F. POPP, M.D., *Councilor*

Thirteenth Councilor District

The 13th District Medical Society will meet on Wednesday, September 28, 1966 at the Elkhart Hotel, Elkhart, Indiana. The program will consist of a late afternoon lecture on mechanism of automobile accidents and injuries received therefrom. Local law enforcement agencies will be invited to attend. The meeting will start at 4:30 p.m.

The business meeting will be held at 5:30 p.m. and a social hour will follow the business meeting.

A dinner is scheduled for 7:00 p.m. and the featured speaker will be Dr. Benjamin Willis, Superintendent of Schools for the city of Chicago. He will talk on educational problems in the large cities and integration problems as they relate to large school systems.

OTIS R. BOWEN, M.D., *Councilor*

Editor of The Journal

The Journal staff is happy to report that it has been possible to operate well within the budget during the past twelve months. Advertising revenue has improved and the observance of past economies and the origination of a few new ones promises to make a small surplus available at the end of the fiscal year.

The Journal format was changed beginning with the July issue to a three-column page for most of the editorial reading matter. A new type face in the same size as was formerly used was selected. These two changes will make a more readable page, even though each page will accommodate more words than were possible under the old format.

In response to numerous readers' requests for more scientific articles written by faculty members of the medical school and in consideration of the growth of and interest in postgraduate medical education, the editors and Editorial Board are consulting with the Dean of Indiana University School of Medicine for the purpose of publishing more scientific material written especially for postgraduate and continuing medical education.

Our stock of unpublished scientific articles has now been reduced to approximately a six-month supply. We shall endeavor to maintain it at this level. With a small increase in advertising revenue we shall be able to accommodate more requested postgraduate instruction articles and still be able to accept most of the short clinical articles and case reports as we have in the past.

Delegates to AMA

An Indiana-sponsored resolution was adopted by the AMA House of Delegates at its annual convention June 26-30 in Chicago.

The resolution called upon specialty groups and specialty boards to impose the Principles of Medical Ethics upon their membership. The House adopted the resolution with the exception of changing the resolve to make it apply to all physicians instead of just specialty groups.

Dr. E. S. Jones of Hammond was elected vice-president of the AMA and Dr. Guy A. Owsley of Hartford City was elected to a five-year-term on the Council of Medical Service. James A. Waggener, Executive Secretary of ISMA, was re-elected for another

term as secretary-treasurer of the Conference of Presidents and Other Officers, a position to which he has been elected for 13 consecutive years.

Indiana received two awards: first place in Class Two, 4,000-9,999, for the largest amount contributed by physicians to AMA-ERF and a first place award in Class Two for the highest per capita giving by physicians.

The Indiana State Medical Association was represented by all AMA delegates and alternate delegates as well as members of the Executive Committee.

Other items which came before the House of Delegates included Federal health legislation, physicians' billing procedures, medical ethics, racial discrimination, health manpower and an increase in AMA annual dues.

Dr. Milford O. Rouse of Dallas, Texas, Speaker of the House of Delegates for the past three years, was named AMA president-elect by acclamation. He will succeed Dr. Charles L. Hudson of Cleveland, Ohio, who took office at the Tuesday afternoon inaugural ceremony during the Chicago convention.

The 1966 AMA Distinguished Service Award was voted to Dr. Warren H. Cole of Chicago, head of the Department of Surgery at the University of Illinois College of Medicine, for his work in cancer research and his many contributions to medical literature.

The Layman's Citation for Distinguished Service was awarded to Danny Thomas, well known entertainer in radio, television, motion pictures and the stage, for his leadership in founding the St. Jude Children's Research Hospital at Memphis, Tennessee.

Final registration reached a total of 35,506, made up of 12,445 physicians and 23,061 guests.

Federal Health Legislation

The House of Delegates received and considered a large number of reports and resolutions dealing with Medicare, the expanded Kerr-Mills program under Title 19 of Public Law 89-97 and other federal laws or programs.

In accepting and commending a board of trustees report on Medicare, the House recommended that "the association give wide dissemination to the information contained therein, particularly its informed discussion of direct billing, the basic purposes of utilization review, the rejection of compensation for service on such committees except in exceptional circumstances, and the proper placement of any onus of responsibility for any failure in the Medicare program."

The board report ended with the following conclusion:

"During the past year many individuals have represented the American Medical Association and the physicians of the United States by meeting frequently with officials of the Department of Health, Education and Welfare. This degree of cooperation on our part should be viewed as a recognition by responsible citizens of an obligation to obey the law of the land, including this law with which we disagree. Our specific purposes have been to provide expert assistance to the government so that this law could be implemented in a manner most helpful to the beneficiaries while disturbing the practice of medicine to the minimum degree. Despite our best efforts it is apparent that serious problems are inevitable in connection with the implementation of this law and we trust that the physicians and the public will place the blame for such deficiencies squarely where they belong — on the Federal Government.

"We are proud of the role we have assumed and in many instances our efforts have been productive. Proposed forms were simplified; some unnecessary forms eliminated, and a number of our suggestions were incorporated in regulations and procedures. An informative 'Reference Guide' for physicians, recently distributed, was prepared with consultation of AMA staff. Numerous other items will continue to receive our most serious study and consideration, and the board urges and requests that every member exhibit his personal diligence by supplying his local medical society documented evidence of transgressions of the spirit or the letter of the law as it is implemented.

"The board of trustees intends to continue to supply advice, guidance, and dissent when necessary to the government or to other third parties on matters that pertain to the health of the public and the interests of the medical profession."

The House strongly supported the general concept of individual responsibility and endorsed a report from the Council on Medical Service which included the following statement:

"Since the Council believes that the current interest in the doctrine of individual responsibility stems in large part from concern over the matter of assignments under PL 89-97, it hastens to add that, as a matter of American Medical Association policy, the Council on Medical Service recommends reaffirmation of the responsibility of individual physicians for determining how they will govern their professional practices under this law and that physicians should be made acutely aware of the manifest superiorities of direct billing as previously communicated to this House in the Council's Report E (A-66) on 'Recommendations on the Physician's Role in Medicare.' "

The latter report (Report E) was highly commended, and the House recommended its widest possible dissemination, including publication in its entirety in a prominent place in the earliest possible issue of *AMA News*.

Physicians' Billing Procedures

In connection with the Medicare part of Public Law 89-97, the House also adopted three resolutions which recommended that physicians use the direct billing method rather than the assignment procedure. At the same time, the House pointed out that adoption of these resolutions should not be interpreted as contravening the statement approved at the Special Session in October, 1965, which said:

"The American Medical Association opposes any program of dictation, interference or coercion, whether direct or indirect, affecting the freedom of choice of the physician to determine for himself the extent and manner of participation or financial arrangement under which he shall provide medical care to patients under Public Law 89-97."

In considering a resolution on the right to bill patients under Title 19 of the law, the House passed an amendment pointing out that direct billing has been recommended as the billing method of choice under Title 18 by the Board of Trustees and the Council on Medical Service. It then said that since there is a wide latitude available to the states in establishing administrative procedures under Title 19, each state medical association should work early and diligently in its own state so that any plan or law adopted in its state for approval under Title 19 would include authorization for direct billing.

The House also instructed the AMA Advisory Committee to the Department of Health, Education and Welfare to do all in its power to implement the intent of the resolution at the national level. In addition, the House urged positive steps to obtain statutory authority for a continuing medical advisory committee under Title 19, and it called on the AMA and the state societies to maintain added vigilance to eliminate any patterns which might subvert the intent of Title 19.

Hospital-based Physicians

The House passed two resolutions involving billing and reimbursement principles affecting hospital-based specialists but also of significance to all physicians. The first said:

"The Principles of Medical Ethics declare that a physician shall not dispose of his services to a third party or 'lay' organization, and

"Title XVIII of Public Law 89-97 recognizes the principle of the separation of professional and hospital costs for services rendered by hospital-based physicians; and

"This principle has been advocated by the AMA, the American College of Radiology, the American College of Pathologists, and many regional organizations, and

"A great number of hospital-based physicians throughout the nation have declared their intention to bill separately for their professional services in keeping with this

principle; therefore be it

"Resolved, That, since separate billing by the physician for his professional services is a preferred ethical practice, it shall be deemed unethical for a physician to displace a hospital-based physician who is attempting to practice separate billing when said displacement is primarily designed to circumvent separate billing."

The second resolution regretted that publication of Medicare Regulations No. 5 was delayed until June 28, three days before the effective date of Medicare, and said that these regulations do not conform to the intent of Congress as expressed in Section 1801 of the Medicare law. It then declared that:

"The House of Delegates instruct the Board of Trustees and the executive vice-president to request from the Social Security Administration an extension of date of final adoption of the proposed regulations of not less than 90 days, in order that the American Medical Association and all other interested medical organizations be allowed reasonable time to study, and to submit, to the Social Security Administration data, views or arguments and pertinent constructive comments and suggestions.

"To preserve the professional independence of medical practice that the Board of Trustees and Officers of the AMA be instructed to immediately inform the membership that Medicare Reg. No. 5 will not apply to physicians (whether hospital-based or not) who

"1. have no financial relationship with a hospital covering medical services to patients

"2. do not accept assignments but bill directly

"*The AMA News* and other appropriate media be used to advise all physicians who are developing contractural relationships with hospitals for professional service that they should delay the finalization of any agreements pending further analysis of the implementing regulations."

Medical Ethics

In acting upon a board of trustees recommendation that a physician may participate in the ownership of a pharmacy or regularly dispense drugs, remedies or appliances or provide eyeglasses to his patients *only when approved by his component and constituent medical associations and when it is determined by them to be necessary in the best interests of the patient,* the House approved the following reference committee statement:

"The Principles of Medical Ethics provide: 'Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.' Your reference committee reaffirms the 1963 House of Delegates interpretation of the words 'in the best interest of the patient,' which reads as follows:

" 'It is the opinion of the Judicial Council that this language was adopted to permit both the practicing physician and the local medical societies to evaluate the many factual situations incident to prescribing and dispensing which are bound to arise in the practice of medicine. Under this language the doctor is permitted to exercise his own best judgment when caring for his patient. It is known that there will be situations when it is necessary or desirable for a physician to dispense or supply what he has prescribed. The Principles permit this to be done. On the other hand, this broad language provides a means by which a component medical society can inquire into the facts of a particular practice. The profession thus can act to prevent abuse of discretion and protect patients from exploitation. In essence this language means that a physician in the exercise of sound discretion may dispense 'in the best interest of his patient'; it does not authorize him to dispense solely for his convenience or for the purpose of supplementing his income.'

"The reference committee approves the goals sought by the board's report, but disapproves its specific recommendations. It notes that mechanisms presently exist for processing charges of deviation from the foregoing ethic and urges that these mechanisms be made vitally active at the local level. When charges of deviation develop, complaints should be made to the local society and vigorously processed by the appropriate committee of that society. If they are not resolved thereby, the complaints should then be carried to the state constituent association. The prudent physician will always seek the guidance of his local medical society in situations relating to ethical conduct."

The House directed the board of trustees to take action as expeditiously as possible to give wide dissemination to the reference committee report.

Discrimination

The House received six resolutions dealing with the subject of discrimination against some applicants for membership in component medical societies. It called attention to the strong position taken by the House in 1964 but pointed out that it is difficult to follow the 1964 directive because there is now no mechanism at the national level whereby a rejected applicant for membership at county or state level may obtain a hearing in order to right an alleged wrongful discrimination.

In lieu of the six resolutions, the House adopted a substitute resolution which directed the Council on Constitution and Bylaws to prepare such changes in the Constitution and Bylaws "as may be necessary to permit the Judicial Council to receive and act upon appeals filed by applicants who allege that they have been unfairly denied membership in a local and/or state society." The House asked the Council to report its recommendations at the 1966 Clinical Convention.

Health Manpower

On the subject of health manpower, the House received reports from the board of trustees, Council on Medical Education and Council on Medical Service and also one resolution. In general, all of them urged the AMA to assume leadership and mobilize its efforts to meet present and future shortages in health manpower. The House approved the board report, announcing appointment of a Committee on Health Manpower, and adopted the resolution. The two council reports were referred to the new board committee.

In taking these actions, the House approved a reference committee statement which included the following:

"Your reference committee is well aware of the drastic shortage of health manpower that is confronting the American public. It is keenly appreciative of the opportunity presented to the American Medical Association to furnish leadership in the solution of this problem. The necessary additional manpower in the medical profession and in allied health professions must be developed. The most effective and efficient utilization of existing health manpower must be made at all times. This is no time to surrender leadership to persons or organizations outside of the medical profession."

AMA Dues Increase

By a vote of 168 to 46, the House approved an increase in AMA annual dues from $45 to $70, effective January 1, 1967, thus confirming a board of trustees recommendation which was given initial approval at the 1965 Clinical Convention.

The House, in approving the dues increase, accepted a reference committee statement which said:

"It is quite apparent that the programs necessary to serve the needs of the members of the association cannot be conducted effectively without adequate financing and it is equally apparent that such adequate financing is impossible without the dues increase requested by the board of trustees. Your reference committee reaffirms its confidence in the judgment of the board of trustees which has in the past and must in the future exercise the most careful and prudent stewardship over the assets of the association. The board of trustees is the committee elected by the House of Delegates to investigate and control the finances of the association. The appointment of any other committee to perform this function would be most inap-

propriate."

Other Actions

In considering 106 resolutions, 38 board reports and at least 20 additional reports from councils and other groups, the House of Delegates also:

Endorsed the **Declaration of Helsinki,** already adopted by the World Medical Association, as a guide to those who are engaged in clinical medical investigation;

Reaffirmed its opposition to the **compulsory assessment** of hospital staff members in order to raise funds for hospital construction;

Reconsidered its action in defining **usual, customary and reasonable** fees and referred the matter back to the Council on Medical Service for further study;

Urged all state and county medical societies to send representatives to the **Third National Congress on Medical Quackery** to be held October 7-8, 1966, in Chicago;

Commended the **American Medical Association Education and Research Foundation** for its accomplishments during the past four years and gave a standing vote of gratitude to Dr. Raymond M. McKeown, AMA-ERF president since 1962;

Strongly endorsed the **AMA Volunteer Physicians for Vietnam** program and urged the entire profession to support it by word and deed; approved a recommendation by the AMA survey team and the board of trustees that the association organize and administer a program of American assistance in **medical education in South Vietnam** supported by the U.S. Agency for International Development; was impressed by a report from Dean Pham Bieu Tam of the Faculty of Medicine, University of Saigon, and urged that the AMA do everything possible to assure that volunteer physicians caring for the South Vietnam civilian population are properly supplied with medicines and other medical supplies;

Adopted a resolution urging constituent medical associations to oppose as detrimental to the public interest, any proposed legislation that would authorize **optometrists** to engage in the diagnosis or treatment of disease or injury of the eye;

Approved, with minor editorial revisions, a final report from the Committee on Maternal and Child Care of the Council on Medical Service dealing with the medical care aspects of **"Combating the Problems of Unwed Parents";**

Agreed with a strong policy statement condemning the **abuse of LSD** and other nonnarcotic drugs, pointing out that the illicit use of LSD is subverting and vitiating important and necessary valid experimental studies, and recommending that the manufacure and distribution of LSD be continued as needed under strict control, with the drug being made available only to competent research workers (physicians trained in its use) on approval of the Department of Health, Education and Welfare;

Reaffirmed its opposition to the compulsory regulation of any **single** method, such as the use of generic terms, of the **prescribing of drugs;**

Offered AMA cooperation, in order to prevent public fear and misunderstanding, to those **foundations and other groups** which request it in clarifying statistical data, visual media and other forms of medical information to be presented to the public so as to provide an accurate view of the problems or problem with which they are concerned;

Adopted a humorous resolution and an equally humorous reference committee report which requested that "in the future full air-conditioning be considered as a prerequisite in the selection of the Headquarters hotel for the annual AMA Convention in those cities where the **psychophysiological effects of heat** may interfere with effective delegatemanship";

Received as information a comprehensive report on the **Relation of Medicine and Osteopathy,** which contains much material pertinent to future policy considerations, and also approved in principle a recommendation that doctors of osteopathy be commissioned in the Armed Forces Medical Services;

Agreed with a report recommending that the core curriculum plan for continuing medical education be *not* approved in its present form, that no further core curricula be developed at this time, and that various methods of continuing medical education be studied under the auspices of the Council on Postgraduate Programs;

Expressed its opposition to the **Hart bill,** S. 2568, and all similar legislation;

Adopted reports from the Council on Medical Service on a **Model Emergency Department Agreement** and on **Multiple Coverage in Voluntary Health Insurance;**

Approved board reports on **Exercise and Physical Fitness,** encouraging state and local medical societies to support the promotion of fitness programs, and on **Venereal Disease Control,** emphasizing the continued need for all physicians to report all cases that come to their attention, and

Authorized the speaker of the House to appoint a **Resolutions Consultation Committee,** purely for editorial advisory purposes, at subsequent AMA conventions.

Presidential Addresses

Calling upon the medical profession for strength and unity in resisting the present socialist trend in this country, Dr. James Z. Appel of Lancaster, Pa., retiring AMA president, told the Sunday opening session that physicians "must participate in the ranks of both political parties and have a voice in the determination of party policy and the writing of party platforms."

Dr. Hudson, in his inaugural address Tuesday, declared that "we shall need all of our intellectual and scientific resources to cope with the new economics of medicine" and to prevent the extension of the Medicare program, without demonstrated need, toward a national health service.

Speaking at the final session of the House on Thursday, Dr. Hudson said that "a demonstration of our ability to perform must clearly indicate not only our competency in the field of medicine, but also our ability to react to a new kind of government thrust into health care." He warned that the real threat to our system of medicine is not in the details of Medicare implementation but in the expansion of the principle of social insurance.

Election of Officers

In addition to Dr. Rouse, the new president-elect, the following officers were named:

Dr. Jones as AMA vice-president; Dr. Walter C. Bornemeier of Chicago, speaker of the House of Delegates and Dr. Russell B. Roth of Erie, Pa., vice-speaker.

On the board of trustees, all for three-year terms, Dr. Homer L. Pearson of Miami, Fla., and Dr. Dwight L. Wilbur of San Francisco were re-elected; Dr. Burtis E. Montgomery of Harrisburg, Ill., was named to succeed Dr. Percy E. Hopkins of Chicago, who did not run for re-election, and Dr. Max H. Parrott of Portland, Ore., succeeded Dr. Raymond M. McKeown, who was not eligible for re-election.

For the Council on Medical Education, Dr. Kenneth C. Sawyer of Denver, Colo., was re-elected, and Dr. James W. Haviland of Seattle, Wash., succeeded Dr. Melvin W. Breese of Portland, Ore., who did not wish renomination.

For the Council on Medical Service, the House re-elected Dr. Charles J. Ashworth of Providence, R. I.; named Dr. Owsley to succeed Dr. Montgomery, and elected Dr. John R. Kernodle of Burlington, N. C., to replace Dr. Roth.

Dr. James M. Klob, Sr., of Clarksville, Ark., was re-elected to the Council on Constitution and Bylaws. Named to the Judicial Council were Dr. Renato J. Azzari of New York City, to succeed Dr. Robertson Ward of San Rafael, Calif., and Dr. George W. Petznick of Cleveland, Ohio, to succeed the late Dr. James H. Berge of Seattle, Wash.

HAROLD C. OCHSNER, M.D.
E. S. JONES, M.D.
FRANCIS L. LAND, M.D.
GUY A. OWSLEY, M.D.
JACK E. SHIELDS, M.D.

Reports of Committees

Executive Committee

Following the close of the 1965 convention, your Executive Committee met for organization and by secret ballot, Dr. Ralph Everly was elected chairman and Dr. E. T. Edwards became a new member of the Executive Committee by virtue of his election to the chairmanship of the Council.

The period from the close of the 1965 meeting until the writing of this report can perhaps be categorically described as being one of the most active years of the Executive Committee. I shall not attempt to detail the various actions inasmuch as they have been published in *The Journal* for every member of the association to review and, in addition, copies of the minutes are regularly sent to members of the Council. Also, a complete file of the activities of your committee is in the hands of the Reference Committee for their review.

Being the so-called "housekeeping" committee of the association, we have met monthly for the transaction of routine association business but much of the year has been devoted to study the various aspects of Public Law 89-97, its impact upon the public of the state, our hospitals and the profession itself. As the years progress, we seem, for some reason or other, to become more involved in legislative activities and the proposal of measures which would have a direct bearing upon the health of our people. We have endeavored to recognize the potential of these legislative acts and to keep our members alert to the problems facing them as practicing physicians.

While the association has for many years attempted to bring about a separation of professional service from hospital service, this situation has come into sharp focus during the past several months. We have not only been aware of the problem, we have reported the same to the Council, who has also been concerned with this situation. As your Executive Committee, we feel that despite all the efforts which have been made by the commissions and committees, and the executive bodies of this association, we have failed to bring about a complete understanding of many of these problems by the individual members of the association.

While since 1949, and even earlier, various problems affecting the profession have been before us, we feel that at no time has the complete understanding and appreciation of these problems been more important than today. In our opinion, organized medicine is faced with one of the greatest decisions in its history. We must decide, and decide now, if we shall remain as a free enterprise profession or whether we shall, by default, become a regimented and federally-controlled profession. We realize that the individual member's first responsibility is that of caring for his patient and with the load that most physicians have today, this consumes the great majority of his time. But somehow we hope that each and every member of this association will find the time and will take the time to make themselves aware of what is going on about them in the field of socio-economic matters and will react in concert to preserve that which we cherish.

The 1967 session of the legislature is upon us and there is no question that many measures will be proposed which will have a bearing upon the welfare of our patients and the welfare of our membership. We would hope therefore that our component societies will immediately begin organizing for the efforts which will be necessary to steer much of this legislation into the proper channels.

We also feel that we need a renewed effort on the part of each of our members to support I-HOPE and its work in attempting to assist in the election of congressmen who believe in the constitutional form of government. We cannot afford to default in this obligation as medicine today is the main bulwark against total socialization in this nation. Therefore, we hope that each and every delegate will take it upon himself, as his responsibility, to actively communicate with his component societies these matters and to encourage increased activity in all fields of association endeavors.

Medical Defense Activities

1. *Malpractice cases.* A year ago, at the time of this report, August 1, 1965, the following three cases were pending before the committee, one of which was closed during the year:

Case No. 307 — Suit filed March 22, 1962. Pending.

Case No. 308 — (Closed.) Suit filed March 10, 1965. Trial by jury. Settled June 29, 1966. (Expense, $1,966.34.)

Case No. 309 — Suit filed December 10, 1964. Pending.

Since August 1, 1965, and up to August 1, 1966, no new cases have come before the committee, making two cases pending at this time as against three unclosed cases at the same time last year.

2. *Medical Defense Fund Statement from August 1, 1965 to August 1, 1966:*

Bank balance, August 1, 1965		$ 587.13
Receipts:		
Dues	$4,909.25	
Interest	492.80	5,402.05
Total receipts		$5,989.18
Disbursements:		
Attorneys' retainer	$3,612.50	
Reimbursement for legal defense	1,966.34	
Total disbursements		5,578.84
Balance on hand, August 1, 1966		$ 410.34

MEMBERSHIP REPORT

	Dec. 31, 1965	July 31, 1965	July 31, 1966	AMA, 1966
1st District				
Gibson	15	15	13	13
Perry	9	9	8	8
Pike	4	4	4	4
Posey	10	10	8	8
Spencer	4	4	4	3
Vanderburgh	236	236	229	227
Warrick	7	7	7	7
TOTAL	285	285	273	270
2nd District				
Daviess-Martin	20	20	19	17
Greene	16	16	14	7
Knox	38	38	40	38
Owen-Monroe	61	61	68	66
Sullivan	15	15	14	13
TOTAL	150	150	155	141
3rd District				
Clark	40	39	41	40
Dubois	24	24	21	18
Floyd	37	37	39	38
Harrison-Crawford	11	11	10	10
Lawrence	24	23	25	23
Orange	9	9	9	9
Scott	4	4	5	5
Washington	7	7	7	7
TOTAL	156	154	157	150
4th District				
Bartholomew-Brown	46	46	50	49
Dearborn-Ohio	20	20	20	19
Decatur	11	11	10	9
Jackson-Jennings	24	24	24	22
Jefferson-Switzerland	28	28	29	28
Ripley	9	9	9	6
TOTAL	138	138	142	133
5th District				
Clay	11	11	12	12
Parke-Vermillion	23	23	23	23
Putnam	15	15	17	17
Vigo	120	119	116	116
TOTAL	169	168	168	168
6th District				
Fayette-Franklin	16	16	15	15
Hancock	22	21	23	23
Henry	39	39	34	34
Rush	14	14	15	15
Shelby	20	20	19	19
Wayne-Union	68	67	66	63
TOTAL	179	177	172	169
7th District				
Hendricks	22	22	20	20
Johnson	29	29	28	28
Marion	1058	1053	1065	1062
Morgan	18	18	20	19
TOTAL	1127	1122	1133	1129

MEMBERSHIP REPORT

	Dec. 31, 1965	July 31, 1965	July 31, 1966	AMA, 1966
8th District				
Delaware-Blackford	124	122	117	109
Jay	15	15	15	13
Madison	101	101	103	81
Randolph	21	21	20	18
TOTAL	261	259	255	221
9th District				
Benton	9	9	8	8
Boone	19	19	19	19
Clinton	20	20	20	20
Fountain-Warren	15	15	14	14
Hamilton	24	24	20	15
Montgomery	27	27	27	27
Newton	5	5	5	5
Tippecanoe	125	121	128	127
Tipton	11	11	11	11
White	12	11	11	11
TOTAL	267	262	263	257
10th District				
Jasper	7	7	7	7
Lake	440	424	423	404
Porter	32	32	43	43
TOTAL	479	463	473	454
11th District				
Carroll	8	8	9	9
Cass	37	37	32	32
Grant	70	68	66	65
Howard	68	68	72	72
Huntington	25	25	22	22
Miami	14	14	14	14
Wabash	25	25	28	27
TOTAL	247	245	243	241
12th District				
Adams	14	14	14	14
Allen	294	291	294	290
De Kalb	23	23	23	23
LaGrange	7	7	7	7
Noble	17	17	16	16
Steuben	14	14	12	12
Wells	37	37	40	41
Whitley	17	17	17	17
TOTAL	423	420	423	420
13th District				
Elkhart	108	108	108	106
Fulton	11	11	11	11
Kosciusko	19	19	16	16
La Porte	100	100	101	95
Marshall	27	27	26	26
Pulaski	5	5	6	5
St. Joseph	236	236	236	236
Starke	7	7	6	6
TOTAL	513	513	510	501
SUMMARY				
1st District	285	285	273	270
2nd District	150	150	155	141
3rd District	156	154	157	150
4th District	138	138	142	133
5th District	169	168	168	168
6th District	179	177	172	169
7th District	1127	1122	1133	1129
8th District	261	259	255	221
9th District	267	262	263	257
10th District	479	463	473	454
11th District	247	245	243	241
12th District	423	420	423	420
13th District	513	513	510	501
TOTAL	4394	4356	4367	4254

The Journal

The report of Journal activity in advertising, for the first time in several years, can be posed in optimistic terms. After several years of serious losses, it appears that between the economy in printing and the increase in advertising, it is going to place *The Journal* program in the black. Advertising revenues the first six months of 1966 is $4,000.00 ahead of last year.

This is a comparative report for the first six months of each year indicated.

	1963	1964	1965	1966
State Journal Advertising Bureau	$16,782.08	$13,474.13	$13,927.88	$18,069.54
Sold Direct by Journal	1,950.60	2,017.10	2,812.74	2,687.76
Total	$18,732.68	$15,491.23	$16,740.62	$20,757.30

Printing Costs

Year	Cost	(Inserts excluded) No. of Pages
1962	$51,291.51	1862
1963	44,212.23	1612
1964	36,139.47	1456
1965	35,957.50	1416
1966 (6 months)	19,543.40	718

Year	Reading	% Reading	Adv. Pages	% Adv. Pages	Total Pages	Av. Pages per Issue
1960	1413	61	919	39	2332	194
1961	1284	67	634	33	1918	160
1962	1308	68	604	32	1912	159
1963	1139	70	487	30	1626	135
1964	1051	71	423	29	1474	123
1965	998	68	464	32	1462	122

RALPH V. EVERLY, M.D., *Chairman*
G. O. LARSON, M.D.
K. O. NEUMANN, M.D.
EUGENE S. RIFNER, M.D.
E. T. EDWARDS, M.D.
OTTIS N. OLVEY, M.D.
LESTER HOYT, M.D.

Student Loan

During the past year the Committee on Student Loan met six times to interview 22 applicants, all of whom were approved for loans. One applicant, however, who was approved for a loan of $1,000.00, withdrew his request. Total loans granted during the year to 21 students amounted to $19,700.00.

The Guaranteed Loan Plan, whereby the association has an agreement with the Indiana National Bank to make loans to students who are approved by the Student Loan Committee, with the students giving security to the bank, became effective December 1, 1963. Under this arrangement, 59 loans, totaling $49,000.00, have been processed, from December 1, 1963 to September 1, 1966.

The association has $20,810.00 on deposit with the bank to guarantee loans totaling $260,125.00.

A report on the original Student Loan Fund under association management from October, 1955, to July 31, 1963, follows:

Total loaned to 117 students....$58,458.36
Total repaid by loanees as of July 31, 1966 ..... 45,382.51

Total amount outstanding, July 31, 1966 .....$13,075.85

Of the 117 who received loans —
82 have repaid in full
*23 are making payments
* 6 have made no payments
* 6 are still in internships — repayment not due until July, 1967

*Payments due on above mentioned 35 loans still outstanding total $13,075.85.

LESTER D. BIBLER, M.D., *Chairman*
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OTTIS N. OLVEY, M.D.
GLENN W. IRWIN, JR., M.D.
E. T. EDWARDS, M.D.
ROBERT HOLLOWELL, Attorney

Building Committee

In May of this year, your association has occupied its new home for a period of four years. During this time the usual "shakedown" procedures on equipment have taken place and generally the facilities in the building are functioning well with the exception of the air conditioning system, which continues to be a source of concern. We are hopeful that the firm which installed it will eventually get all the "bugs" out so that we will have a trouble-free and uninterrupted operation.

Added improvements have been made in the building, such as the basement area which has served well as a meeting room for large groups. We express our appreciation to the woman's auxiliary who annually have made a sizeable contribution to the completion of the basement area, having given almost $4,000.00 for this purpose.

We have not, as yet, been able to complete the warming kitchen arrangements in the building, although contributions for this purpose now total over $1,700.00. We are hopeful in the next few years that additional contributions will enable us to provide this additional facility for the benefit of the members who have occasion to meet in the building.

The activities and use of the building by

committees, commissions and medical groups are progressively increasing as well as the use of the facilities by the woman's auxiliary. Visitation by members of the association to view the building has shown an increase and we appreciate no end the complimentary remarks we have had from the membership concerning the functional design, the decoration and facilities the building offers the medical fraternity of our state.

The past four years has also seen a tremendous growth in the area surrounding our building. The area from 40th Street south to 38th is practically solid with new buildings, all erected since ours was constructed. Your committee believes the Council was wise in acquiring the adjacent properties to the east so that our present property runs all the way through from Meridian Street to Pennsylvania Street. This is the only possible means for affording the association room for future expansion when conditions in the coming years make this necessary.

The investment by the association in its present home and property was reflectively a wise one. The appreciation of real estate values in the area has been unbelievable and we feel the membership can take pride in the part it has played in the development of this section of the city of Indianapolis.

RALPH V. EVERLY, M.D., *Chairman*
FREDERIC W. BROWN, M.D.
R. CASE HAMMOND, M.D.
JACK E. SHIELDS, M.D.

Reports of Commissions

Constitution and Bylaws

The Commission on Constitution and Bylaws has had several matters referred to it for consideration and makes the following recommendations for changes in the Bylaws:

AMENDMENTS TO BYLAWS

(1) That Chapter IV-Section 8 of the Bylaws be amended by deleting the following: "or any changes in the Constitution and Bylaws." The Section would then read as follows: Sec. 8. "The final vote on any issue calling for changes in dues or in dues structure shall be by roll call vote. Each member's vote shall be permanently recorded and no suspension of this rule will be allowed on the final vote of such an issue."

(2) That Chapter 1 of the Bylaws be amended by adding a new Section to be numbered Section 1 as follows:

"Sec. 1. Every County Society shall include by January 1, 1967, as a part of their Constitution or Bylaws the following: Every person becoming an active member after January 1, 1967, shall occupy a provisional status for two years immediately following his admission to membership in this Society, during which period he must successfully complete an orientation course to be presented at stated intervals by the Council of the Indiana State Medical Association or one of its Commissions. The form and content of this course shall be prescribed by the Council of Indiana State Medical Association. Unless excused by the said Council for good cause shown, failure to attend and successfully complete the course within the two-year period shall automatically revoke the delinquent's membership and terminate all of his rights and privileges as a member, and he shall thereafter, for a period of one year, be ineligible for membership in any component county society."

The present Sections of said Chapter 1 of the Bylaws shall be renumbered to follow in chronological and proper sequence.

The purpose of this amendment is to carry out the recommendations of Doctor Wood, as approved by the House of Delegates, and referred to this commission for implementation. We have used the form of a required provision in the Bylaws of the county societies to avoid any necessity of amending Section 4 of Chapter XXVII of the Bylaws, which makes a county society the judge of qualifications of its members and Section 2 of Article IV of the Constitution, which automatically makes members of the county societies members of the state Association; much of the wording is from the Constitution and Bylaws of the Kentucky State Medical Association.

(3) That Chapter XXVIII, Section 1 of the Bylaws be amended by deleting the following words: "provided such members of County Medical Societies have paid their membership dues in the District Society"—with this amendment said Section will read as follows: "Sec. 1. A Councilor District Medical Society, hereinafter called the District Society, shall be a society whose members consist of the members of the County Medical Societies in the Counties which constitute the Councilor District."

(4) That Chapter XXVII, Section 4 be amended by inserting after the first sentence and before the second and last sentence the following: "Provided, however, that each county society may deny membership in such society for infraction or violation of any law relating to the practice of medicine or of the Constitution and Bylaws of such society, the Constitution and Bylaws of the Indiana State Medical Association or for a violation of the Principles of Medical Ethics of the Indiana State Medical Association; and may, after due notice and hearing, censor, suspend or expel any member for any such infraction."

(5) That Chapter XXVII of the Bylaws be amended by deleting therefrom present Section 8, which now reads as follows: "A physician living on or near a county line may hold his membership in that county most convenient for him to attend, on permission of the society in whose jurisdiction he has his office or has the major part of his practice," and by substituting in lieu thereof the following: "Sec. 8. A physician who has the major part of his practice in a county other than the county in which he resides may hold his membership in the county society of his residence or in the county society of the county in which he has the major part of his practice. However, no physician shall hold active membership in more than one county society at the same time."

(The purpose of this amendment arises out of the fact that there has more or less recently developed situations where physicians have the major portion of their practice in one county but reside in another county but not on or near the county line. Former Section 8 was limited to where the physician lived "on or near the county line." The amendment is to clarify the situation of a physician living in one county with the major portion of his practice in another county regardless of whether he lives on or near the county line.)

AMENDMENTS TO CONSTITUTION

The Commission on Constitution and Bylaws makes the following recommendation for changes in the Constitution:

(1) That Article IV, Section 2, of the Constitution be amended by inserting after the word "the" in the last line the following words "District Medical Society and in," which would make this Section read as follows: "Sec. 2 — Active Members — The active members of this Association shall be the members of the component county medical societies, and no county medical society shall grant active membership therein on a basis that does not include membership in the district medical society and in the Indiana State Medical Association."

(2) That Article VII of the Constitution be amended by inserting after the words, "such societies to be composed exclusively of" and before the word, "members" the word "all" which would make the article read as follows:

"Article VII — The House of Delegates may provide for a division of the scientific work of the Association into appropriate sections; and for the organization of such Councilor District Societies as will promote the best interests of the profession, such societies to be composed exclusively of all members of component county societies. Councilor districts shall be defined by the House of Delegates."

MATTERS NOT RECOMMENDED

(1) There was referred to this commission a letter from Dr. P.J.V. Corcoran concerning permitting the alternate councilor to the councilor serving as chairman to have a vote while the regular councilor is in the chair. This letter was considered and it is recommended that this suggested change should not be made for the following reasons:

a. The chairman of the Council may step out of the room and allow his alternate to vote.
b. If the chairman was from a relatively small district, giving his alternate the right to vote would be unfair to the other districts, inasmuch as the chair does have the right to vote.
c. The chairman of the Council can and does represent his district.

(2) There was referred to this commission from the January 23, 1966 council meeting the matter concerning re-apportionment of delegates. This matter has been studied and reviewed and the commission recommends that no change be made in the present method of selection of delegates. It is the opinion of the commission that the present method of selecting delegates is fair and equitable. It should be noted that each county medical society, even though it is a joint society, regardless of the number of members, is entitled to one delegate. The present apportionment of delegates is on the basis of one delegate for every 50 members or major fraction thereof. Therefore, every delegate represents a maximum of 50 members of his county except in the case of those delegates from societies having less than 50

members, and in these cases the delegate's ratio of representation is further reduced. It is our opinion that the present method is equitable and that no changes should be made.

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RICHARD L. GLENDENING, M.D.
MAURICE E. GLOCK, M.D.
EDWIN C. MUELLER, M.D.
BURTON KINTNER, M.D.

Legislation

Your commission held several meetings during the year to discuss the mass of legislation passed and pending passage in the 89th Congress. Roughly there has been a 50% increase in legislation affecting medicine during this present session of the Congress. As always we have relied upon the Council on Legislative Activities of the AMA for information and for representing us on the many issues at hand in Washington. Your chairman along with our medical legislators, Senator James Kirtley and Representative Otis Bowen, and the Executive Committee of Indiana State Medical Association attended the annual dinner in April, 1966, for the Indiana Congressional Delegation. These two days in Washington enabled us to maintain our relationships with the legislators and to speak in behalf of the physicians of Indiana.

Your commission, along with interested physicians in other commissions and in other positions in Indiana State Medical Association have sought out information on possible legislation to be introduced in the 1967 session of the Indiana General Assembly. In this area, the State Commissioner of Health, Dr. Andrew Offutt, and his staff, have been extremely cooperative and helpful. There are many items which may be presented to the legislature. Listed below are some which your commission has discussed and will be watching carefully in the 1967 session. If any member of Indiana State Medical Association has especial interest in any of these items or any others, his comments and help will be appreciated:

1. A bill for licensing psychologists for "private practice" has been prepared by the Indiana Psychological Association. We continue to oppose the parts of their bill which encroach on the practice of medicine.
2. It is proposed there be legislation to protect physicians who examine and treat teen-agers with venereal disease.
3. Your legislative commission has urged that Indiana State Medical Association support and work for an amendment to the Forensic Science Law of 1963 in order to work toward a more effective medico-legal investigative system.
4. Your commission is working on means to strengthen and clarify the Medical Practice Acts. It is hoped this can be accomplished without resorting to legislative action.
5. There is a proposed Hearing Aid Bill which purports to certify sellers of hearing aids and "to recognize pathological problems of the human ear." This proposed bill is strongly opposed by otolaryngologists as well as the audiology departments of state schools. It will be vigorously opposed by your legislative commission as well.
6. The Guild of Prescription Opticians of America has proposed licensing of opticians in order to aid in better medical eye care for the public. Also there has been discussion relative to development of a labeling (standardizing) law for opthalmic lenses.
7. Also anticipated are bills (1) to provide services for multi-handicapped children; (2) to change laws relating to epilepsy; (3) possible regulation of LSD and (4) an implied consent law for drivers. The latter pertains to alcohol testing of drivers involved in auto accidents. Also (5) there is interest in a law for "privileged communications" to aid forensic psychiatry. (6) There has been increased interest in changing the present abortion laws.
8. One of the major health legislation bills will be the implementation of Title 19 of the 1965 amendments to the Social Security Law. Your state association has been consulted by the State Welfare Department on this far-reaching, so-called extension of the old Kerr-Mills Law.
9. There will be legislative action of some type relative to medical education in Indiana. It is not certain whether this will be towards a second medical school, extension of the present medical school, via the "Indiana Plan" or a combination of the two.

As usual and fitting there has been interest and activity toward Political Action Courses and efforts to activate all doctors and their families to participate in the political party of their choice. The auxiliary to the Indiana State Medical Association has been most helpful in these areas and again your commission appreciates their efforts and solicits their continuing support on legislative and political matters. All Indiana State Medical Association members and members of the Indiana State Medical Association auxiliary are urged to give practical action to their legislative program through monetary support of I-HOPE and AMPAC.

The legislative commission sponsored a Speech Training Seminar on April 27, 1966, which was well received.

Your commission again wishes to thank the officers and members of Indiana State Medical Association for their support and special thanks to Jim Waggener and his staff for their excellent cooperation and support of the commission's efforts.

DWIGHT W. SCHUSTER, M.D., *Chairman*
EUGENE F. SENSENY, M.D., *Vice-Chairman*
JACK W. HICKMAN, M.D., *Secretary*
DANIEL M. HARE, M.D.
HAROLD MANIFOLD, M.D.
ELMER L. WALLACE, M.D.
LESLIE M. BAKER, M.D.
FRED W. DIERDORF, M.D.
JOHN DAVIS, M.D.
PHILIP ROSENBLOOM, M.D.
ROBERT G. YOUNG, M.D.
OTIS R. BOWEN, M.D.
DON E. WOOD, M.D.
JOE BLACK, M.D. *(ex-officio)*
JAMES M. KIRTLEY, M.D. *(ex-officio)*

Public Information

1. *"Doctors At Work" Film Series* — The commission saw, during 1966, the culmination of two year's planning come to fruition with the utilization of this unusual medical film series. The films, planned for television usage, were utilized by four television stations throughout the state including WNDU-TV, South Bend; WLBC-TV, Muncie; WISH-TV, Indianapolis and WFAM-TV, Lafayette.

They were additionally utilized by the Indiana University School of Medicine; by leaders of medical explorer scout troops, by nursing training classes and by individual physicians.

As of the writing of this report, July, 1966, the headquarters office had made approximately 100 mailings of the series. The entire series will be returned to the California producers at the end of this year. The cost of leasing the series was underwritten by Merck, Sharp and Dohme.

The commission feels strongly that such programs as this television series should be continued and that serious thought should be given by the Budget Committee of the association, annually, to allocate, for public relations purposes, a specific amount for the purchase of appropriate educational materials which are requested through this office and for development of additional public relations programs which would possibly in-

volve a similar film series, contingent upon the approval of the Commission on Public Information and, of course, final ratification by the Executive Committee and Council of the state medical association. The commission wishes to include these remarks in its report since the television film series was delayed two and one-half years pending the acquisition of funds from outside sources.

2. *Journalism Awards Program* — The public information commission continued with the awards program established in 1965, making this the second annual awards program with recognition for the communications media planned for the French Lick convention.

Last year's awards included awards to the following: WISH-TV, Indianapolis; WFBM-TV, Indianapolis; Miss Joan Evans, Radio Station WIBC, Indianapolis; Harrison Ullmann, *The Indianapolis Star;* WFBM-Radio, Indianapolis and *The Greensburg Daily News.*

At the writing of this report the commission is considering award applications for the 1966 convention. The commission feels that such awards are a positive way of recognizing good works in the field of health by the media, and would encourage all medical societies to seriously give thought next year to presenting to the commission applications for individuals, newspapers, radio and television stations, which have made noteworthy contributions to the profession and for the betterment of the health of Hoosiers.

3. *Pamphlet for New Physicians* — At present the staff of the headquarters is developing a brochure on the services and programs of the Indiana State Medical Association. Since this brochure is considered a part of the internal public relations program of the association, the Commission on Public Information will review and make recommendations on the brochure.

4. *Medical Self-Help Series*—Although the Commission on Governmental Medical Services is charged with the responsibility of developing this program, the Commission on Public Information is working in cooperation with this commission to develop appropriate materials for public dissemination. The training series will begin in January, 1967, on television station WTTV-TV, Channel 4, Indianapolis.

5. *Indiana State Fair Exhibit* — The State Fair exhibit each year has been one of the outstanding public relations events of the association and the acquisition of an appropriate exhibit is routinely handled by the headquarters office. As a reminder to the association membership, medical students take blood pressures and staffing of the exhibit is managed by the woman's auxillaries of the Marion County Medical Socity and surrounding county societies. This year, however, and in 1967, this association and other like organizations will not participate in the exhibit since the area usually allocated under the direction of the Indiana State Board of Health is being occupied, at the request of the State Fair Board, by a sesquicentennial exhibit.

6. *Junior-Senior Day Publicity* — Appropriate pictures and story material on this annual event was provided to the press, to the *State Medical Journal* and to AMA publications. The program is designed to encourage junior and senior medical students to consider practicing medicine in rural Indiana. Programming of the event falls within the responsibility of the Commission on Public Health, while its publicity is handled through the Commission on Public Information on a routine basis by the headquarters staff.

7. *Convention Publicity* — Under the direction of the commission, the headquarters staff continues to provide adequate facilities for press usage at each annual convention, in addition to providing at least six advance releases on the convention each year to all newspapers in Indiana. Here again the headquarters staff assists reporters and radio and television newsmen to obtain details of the convention, personal interviews and specifically requested information. Part of good public information is to facilitate access for media representatives.

8. *Youthpower Conference* — Working in cooperation with approximately 20 other associations and organizations, the Indiana State Medical Association helped program and finance this annual affair which is primarily a program of the Indiana Farm Bureau. This year the ISMA displayed an AMA exhibit entitled, "A Career in Medicine" and distributed a pamphlet entitled "Opportunities and Rewards in Medicine," to the 150 outstanding youngsters from throughout the state who attended the two-day affair in the Severin Hotel, Indianapolis. The association also provided 200 copies of the excellent AMA publication, entitled, "The Wonderful Human Machine."

9. *Medicine and Voluntary Health Day* — This first annual event, sponsored by the Commission on Voluntary Health Agencies and the recognized voluntary health agencies of the state, was promoted and publicized in large part through the ISMA and the program was considered one of the highlight extensions of the Indiana Public Health Association's annual convention. Here again, the publicity involved was under the jurisdiction of the Commission on Public Information.

10. *Information Center* — The headquarters again this year acted as a clearing house for thousands of pieces of educational materials requested by teachers, student counselors, club groups, Student American Medical Association members, Welcome Wagon hostesses, Health Careers Incorporated, students and others. The volume of such requests continues to grow.

11. *Preceptor Program* — The commission would like to include in its report to the House of Delegates of the association the outstanding publicity benefits which accrue from such excellent programs as initiated and made operative by the Commission on Medical Education and Licensure. Over the past two year period, stories have been placed with *The Indianapolis Star Magazine* and in the news pages of that paper. In addition, during the spring of this year, a Muncie, Indiana newspaper printed a full two-page spread with pictures and story on the conduct of the program there. Pictures and story material of this caliber enhances the image of the physician and his medical organization. The commission would like to emphasize this fact with all medical societies by stating that one good public relations program a year, conducted by a county medical society, can help sustain and certainly improve the individual and collective image of that society.

HARRY G. BECKER, M.D., *Chairman*
STUART R. COMBS, M.D., *Vice-Chairman*
GLEN McCLURE, M.D., *Secretary*
L. EDWARD GAUL, M.D.
JOHN K. SPEARS, M.D.
CHARLES A. RAU, M.D.
ROBERT D. SPINDLER, M.D.
HOWARD FAUST, M.D.
FRED M. BLIX, M.D.
THOMAS C. CHAEL, M.D.
FRED C. POEHLER, M.D.
FREDERIC L. SCHOEN, M.D.
LOUIS F. SANDOCK, M.D.
WILLIAM G. MOORE, M.D.
LOREN H. MARTIN, M.D.

Governmental Medical Services

1. *Disaster Preparedness*

The Sub-Committee on Disaster Preparedness under the direction of Dr. Jerome Holman, Jr., continued during the year with preparation for the Medical Self-Help TV series. Definite arrangements have been made for utilization of this series of 15 one-half hour programs on WTTV-TV, Channel 4, Indianapolis, beginning in early January, 1967. The program, initiated by the Indiana State Medical Association commission is being cooperatively sponsored by the Indiana State Board of Health and the state society's woman's auxiliary. The purpose of the series is to teach classes by way of instructional television. It is hoped that prior to the January deadline, several groups from industry, community organizations, youth groups, as well as individuals, will be enrolled. Certificates of completion will be awarded to individuals who complete the course.

The commission is planning to circulate 150,000 advance brochures throughout the 42 county, Channel 4 coverage area. This series has been the culmination of two year's continuous effort by the sub-committee.

2. *Old Medicare and Dependents' Care*

During the fiscal Medicare year, April 1, 1965 to March 31, 1966, the Medicare Department reviewed 5,968 new claims. Concerning the administrative functions of the Medicare Department for the fiscal period, 3,002 claims were cleared; 2,756 claims were returned for additional information and 512 claims were rejected as unqualified for payment. Total claims paid numbered 5,013 and the value of checks issued during this fiscal period amounted to $400,402.31.

It was the function of this sub-committee membership, Dr. Edward J. Dierolf and Dr. James E. Wenger, to review questionable claims in this particular department of the state medical association's operation.

3. *Liaison Veterans' Affairs*

The Commission on Governmental Medical Services has remained active in this area during the year. During the spring meeting of the liaison group, representatives who are delegated from the Indiana State Medical Association, Indiana Hospital Association, Indiana State Dental Association, Indiana Department of American Legion and the Indiana Pharmaceutical Association, the group discussed, primarily, the impact of Medicare as it pertained to each of the representative organizations. Dr. Herman Echsner, a member of the committee, and Mr. Kenneth Bush, a member of the administrative staff of the Indiana State Medical Association, were present for this meeting and discussed Medicare in some detail. Dr. Echsner did an excellent job of informing this group of the particular circumstances of the individual practicing physician as it involved his personal practice from the viewpoint of ethics and administrative complications.

4. *Veterans' Medical Care*

During the year, too, representatives of the Commission on Governmental Medical Services met with representatives of the Veterans' Administration to discuss preparation of a pilot test of fee and billing procedures. This test, which is also being conducted in two other states, is for the purpose of establishing a possible precedent which will allow physicians to bill the Veterans' Administration without the filling out of complicated forms. Physicians handling veterans' medical problems may charge their regular fees, utilizing their own billing procedures. If the results of the study are positive, the procedure for billing will be made applicable to all states.

5. *Mental Health*

The comprehensive Mental Health Plan for the State of Indiana was completed, approved and accepted on March 30 of this year. As a consequence of the surveys necessary to develop this plan and the final writing of the plan itself, many cities and/or regions of the state are now working on plans to establish portions of, or complete Comprehensive Mental Health and Mental Retardation Clinics.

The State Commissioner of Mental Health resigned from his office effective July 31, 1966. Dr. Donald Moore, the Superintendent of LaRue Carter State Hospital has been named as acting commissioner until a new commissioner is appointed.

Dr. J. R. Gambill will continue as deputy commissioner at this time.

Dr. Grant E. Metcalfe, Chairman of the Advisory Council for Mental Health to the Governor, has named a screening committee of three members from the Council and seven doctors as consultants to the screening committee to aid in the selection of a new Commissioner of Mental Health for Indiana and to recommend such selection to the Governor for appointment.

The commission met two times during the year on November 14, 1965 and March 9, 1966. During these meetings the commission exchanged information on such activities as government pamphlets on health and hospital facilities; federal programs on rehabilitation; billing procedures under the Medicare program; the interpretation of the customary fee concept; hospital utilization committees; the Veterans' Fee Schedule and Title 19 of the Medicare Law.

OKLA W. SICKS, M.D., *Chairman*
GLEN WARD LEE, M.D., *Vice-Chairman*
JEROME E. HOLMAN, JR., M.D., *Secretary*
WILLIAM C. FISHER, M.D.
CHARLES HENDRIX, M.D.
GUY H. WALDO, M.D.
HERMAN ECHSNER, M.D.
DICK J. STEELE, M.D.
ROBERT P. SCOTT, M.D.
J. F. HINCHMAN, M.D.
RAMON B. DUBOIS, M.D.
EDWARD J. DIEROLF, M.D.
ERNEST C. MURRAY, M.D.
GEORGE D. BUCKNER, M.D.
JAMES E. WENGER, M.D.

Public Health

The Commission on Public Health has concentrated its efforts during the past year on completing the programs that were begun in previous years. "The Guide for Industrial Medicine" included in the 1965 report published in *The Journal* at the time of last year's convention was recommended for distribution to all new physicians within the state. It was, however, the consensus of the Council that inasmuch as this was available as a current publication, that publication as a separate brochure would not be advisable at this time. The commission still considers this a matter of some import and suggests that the material should be presented either in a brochure form or as a *Journal* reprint for distribution to all physicians newly arrived for practice in the state of Indiana.

It is suggested that the Council consider seriously the proposition previously made that all pertinent publications of the Indiana State Medical Association such as this "Guide to Industrial Medical Practices," policy and procedures relative to medical practice and perhaps a brief explanation of the legal requirements peculiar to this state be made available to all new physicians as they come into this state to practice medicine. I personally feel that the distribution of such materials to graduating seniors is much less effective than to doctors completing their internships, residencies or who are newly registered for practice in the state of Indiana.

The campaign for eradiction of tuberculosis as a joint effort of the Indiana State Medical Association, Indiana State Board of Health and the Tuberculosis Association is progressing, but official reporting methods indicate only spotty adherence to the requests for information. A different approach to bring this to the awareness of all physicians might be of some value, and is currently being considered.

Junior-Senior Day was again apparently a success as judged by the remarks from the 150 students and their wives who attended. A program prepared by Dr. Neal Petry of Delphi, included a panel which discussed various aspects of general practice from the standpoint of physicians' families, professional satisfaction and some of the business aspects. A delightful address by Doctor Rifner highlighted the rewards, both tangible and intangible, that one can obtain from the general practice of medicine. It was decided that the commission would devise a questionnaire to try to determine the effectiveness of this program toward influencing medical students in a career in general practice. Saturday, April 1, 1967, has been selected as the date for the next Junior-Senior Day.

The committee considered the article prepared by Doctor Haggard dealing with the Social Security Disability Program in Indiana and recommended that the principle of this be approved by the Indiana State Medical Association. Publication of this article would have to be at the expense and under the auspices of Doctor Haggard and the Social Security Administration, Disability Determination Division.

A report of the member of the commission who attended the American Medical Association Congress on Environmental Health Problems is appended. Information obtained

by Doctor Schultheis will be of considerable importance in evaluating studies in traffic safety as well as those environmental factors which have an effect on other accidental injuries and fatalities. It should be noted that accidents are still the leading cause of death, and that practically all of them are preventable. As much of the environment is man-made and can be manipulated to improve its safety factors, there is much that could be done to decrease the risks apparent in everyday activities. This does not obviate the personal factor, but serves to point up our responsibility to help individuals adjust to their environment with a minimum of negligence.

An example of environmental factors which are significant in accidents is the accumulation of waste products, particularly carbon monoxide, in and about every stream of slow moving traffic. A report from the Traffic Safety Committee indicates that the study previously proposed to the Council is being pursued. It is felt that the data evolving from this study will help immeasurably in establishing standards for driver qualification and eliminating certain driving risks by selective restrictive driving privileges. Approval and token support of this project under the direction of Robert Borkenstein, Ph.D., will add immeasurably to the stature of the project and the application of its findings.

The School Health Committee has participated in discussions during this past year with representatives of the Department of Public Instruction and the Indiana State Board of Health as well as the Indiana Chapter of the Academy of Pediatrics. It is requested that time on the program of the 1967 Indiana State Medical Association convention be designated for school health. The Indiana State Medical Association, through this commission, would be host to superintendents from each of the state's school corporations. These discussions would deal primarily with relationships of physicians and school administrators in the fields of school health, health education, at both elementary and secondary levels, and the common interests which these professional persons have in current school programs such as those established under the Elementary-Secondary Education Act of 1965 (P.L. 89-10).

The future for the commission is one of increased activity. It is hoped that there can be more coordination with the Indiana State Board of Health and with other state agencies particularly in regard to the control of venereal disease and tuberculosis. The ability of the commission to coordinate with other professional groups and organizations within the state has been enhanced by various meetings, and it is anticipated that these will increase the influence as well as the capabilities of the commission to improve the general health situation within our state.

Meeting of Third AMA Congress of Environmental Health Problems — Drake Hotel, Chicago, April 4-5, 1966

Impact of Environment on Accidental Injuries and Fatalities

The meeting included discussions by outstanding men in their fields such as Ross A. McFarland, Harvard School of Public Health; Ira Blumenthal, National Safety Council Research Department and Abraham J. Mirkin, M.D., Chairman, AMA Committee on Medical Aspects of Automotive Safety.

These notes are disjointed and not necessarily in sequence, but they represent the significant information gleaned from this meeting.

Accidents are a combination of factors. Small accidents lead to the large ones. Environmental factors are becoming more man-made and so, therefore, manipulatory.

Accidents killed in just the last one and a half years the same number of people as died in the 1918 flu epidemic.

Practically all accidents are preventable; however, to move is to take risks; the primary effort is to make this moving a good risk taking, i.e., crossing the streets in the proper place, with the lights, etc.

Accidents are the leading cause of death up to the age of 37.

In reference to exposure to glare, it is directly proportionable to the increase of age, i.e., recovery is slower. The older the individual the more his glare tolerance decreases. It takes two and one-half times more light for a person in his sixties to see adequately than a person age 30, night or day.

The behavior of a person is involved and is a very significant factor in the cause of accidents; therefore, it is important to appreciate the risks in one's environment.

Accidents are not really accidents per se. They are negligent acts. Unfortunately, the general definition colors and obscures our concept of accidents. There are two basic truths involved here:

1. Accidents are bad.
2. Anything which can be done to prevent accidents is good for people.

Two significant factors involved in the human causes of automobile accidents are fatigue and carbon monoxide which lessen the perceptions, particularly at night. Carbon monoxide gathers from standing in heavy traffic or in slow moving traffic, and there is an increase in the carbon monoxide concentration as the fumes accumulate in the car.

Each thirteen years of age doubles the intensity of light required to maintain threshold levels of light perception. Older people should not be allowed to drive at night. Tinted windshields also contribute to the poor light adaptation. Red-green color blindness is not an important factor.

People with chronic medical conditions have two times the number of accidents as a normal person and 1.8 times the number of traffic violations. Acute medical conditions which affect driving such as a patch over the eye, casts, etc., also contribute; however, no specific figures were given in this connection.

A single accident is often of several etiologies. The most well-defined are those of age and visual changes. There is no one single cause but probably a group of factors or patterns which will need to be discovered. It is necessary that we determine and investigate these in the approach to a pre-accident analysis.

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DANIEL A. GARD, M.D. *(Ex-Officio)*
RICHARD L. SCHULTHEIS, M.D., *(Ex-Officio)*
EMERSON C. HARVEY, JR., M.D. *(Ex-Officio)*

Voluntary Health Agencies

This commission is made up of the following:

(1st Distr.) James R. Mathews, 715 First Ave., Evansville
(2nd Distr.) Ed R. Cantwell, 202 Broadway St., Vincennes
(3rd Distr.) William R. Noe, 2900 W. 16th St., Bedford
(4th Distr.) Robert Aeher, 221 E. Washington St., Greensburg
(5th Distr.) William G. Bannon, 500 Rose Dispensary Building, Terre Haute
(6th Distr.) Lucian A. Arata, 327 W. Broadway, Shelbyville
(7th Distr.) William A. Karsell, 3989 Meadows Dr., Indianapolis
(8th Distr.) James S. Fitzpatrick, 603 W. Arch St., Portland
(9th Distr.) Albert E. Applegate, 1303 S. Jackson St., Frankfort

(10th Distr.) Walfred A. Nelson, 559 S. Lake St., Gary
(11th Distr.) Wendell Ayres, 500 Wabash Ave., Marion
(12th Distr.) R. G. Taylor, 2902 Fairfield Ave., Fort Wayne
(13th Distr.) William F. Oren, 919 E. Jefferson Blvd., South Bend
(At Large) James Gosman, 2901 N. Meridian St., Indianapolis
(At Large) Norman R. Booher, 447 E. 38th St., Indianapolis
(Consultant) Doris H. Merritt, 1100 W. Michigan St., Indianapolis

The organizational meeting was held on November 14, 1965, at which time Robert Acher, M.D., was elected secretary, James Gosman, M.D., was elected vice-chairman and Norman Booher, M.D., was elected chairman.

The members of the commission were assigned to one or more of the voluntary health agencies having state programs in the state of Indiana to act as liaison with these agencies and to become specialists in their affairs. As the questionnaires on the standards under which this commission operates were received from each of the agencies, the data was assigned to the member of the commission acting as liaison representative for the individual agency.

Throughout the year these individual members applied the criteria (these criteria were published in the annual report of this commission for 1964) and made recommendations to the commission relative to the recognition of each individual agency. In this way members of the commission became very familiar with the program and organization of the voluntary health agencies in the state and became acquainted with many of the lay people working in the various agencies.

At the November 14 meeting, it was decided that this commission should join with the 13 voluntary health agencies recognized as meeting our criteria in the promotion of a joint educational meeting. It was also felt that whenever any booth space at the annual meeting could be made available on a free basis to the voluntary health agencies cooperating with the association, that this should be done because of the public relations impact and the common goals in health of these agencies and the state medical association. This was recommended to the Council of the Indiana State Medical Association.

On Sunday, January 30, the members of the commission met and held their regular business session in the morning and in the afternoon met with the executives and presidents of 11 of the state voluntary health agencies. These agencies were asked for suggestions and criticism of the program being pursued by this commission. Some helpful suggestions were received and very little criticism. It is obvious that the representatives of voluntary health agencies welcome the opportunity to communicate with Indiana State Medical Association and much helpful discussion took place.

As a result of this January 30 meeting a committee was appointed to work up the program of the joint meeting sponsored by Indiana State Medical Association and the voluntary health agencies and it was decided that this meeting would be held in conjunction with the annual meeting of the Indiana Public Health Association on April 28. This decision was reached because of convenience of date and place — it was felt it would be satisfactory for a first meeting of what it was hoped would be an annual affair. A committee, headed by Mr. William C. Wilson, Executive Secretary of the Indiana Tuberculosis Association, and others from the agencies and the Indiana State Medical Association was appointed.

The commission also met jointly with the representatives of the voluntary health agencies on February 9, at which time the details of the meeting on April 28 were worked out and speakers were discussed.

On April 28, the first of the annual joint meetings sponsored by the Commission on Voluntary Health Agencies of the Indiana State Medical Association with recognized voluntary health agencies was held. This meeting was held as the entire afternoon program of the final day of the annual meeting of the Public Health Association. In order to present timely topics with a maximum of information, a somewhat unusual format was undertaken. Each speaker was allowed 30 minutes to present his subject and then was subjected to intense questioning by members of the news media from four different areas of Indiana. The speakers were:

John W. Cashman, M.D., Chief, Division of Medical Care Administration, Public Health Service, Washington, D. C. Subject: Medicare

Robert A. Rosekrans, Assistant Director, Community Service Activities, AFL-CIO, Washington, D. C. Subject: Labor's View of New Federal Health Programs

Glenn W. Irwin, Jr., M.D., Dean, Indiana University School of Medicine, Indianapolis. Subject: Indiana University's Role in Regional Complex Plan

Leo E. Brown, Assistant to Executive Vice-President, American Medical Association, Chicago. Subject: Voluntarism and Health

and the news media people were:

Harrison Ullmann, Science Writer, *Indianapolis Star;* Mrs. Helen Ryan, Director of Special Events, WTHI-TV, Terre Haute; Walton R. Collins, Associate Editor, *South Bend Tribune;* Jerry Huddleston, Science Writer, *Fort Wayne Journal Gazette.*

The attendance at the meeting was approximately 500.

This type of meeting seemed to be well received. It is planned that a similar meeting will be held next year and it is hoped that by this time that the board advisory committee to the Commission on Voluntary Health Agencies, authorized by the House of Delegates in 1965, can be operative.

It has become obvious to the commission that the idea originating in Indiana for national accreditation of voluntary health agencies is gaining momentum and is almost certain to come in some form.

Finally, the voluntary health agencies having a state-wide program that are recognized under the present criteria are:

American Cancer Society, Indiana Division
Indiana Chapter of the Arthritis Foundation
Indiana Society for Prevention of Blindness
The Indiana Society for Crippled Children and Adults, Inc.
Tri-State Epilepsy Society, Inc.
Indiana Heart Association, Inc.
American Rehabilitation Foundation
Indiana Association for Mental Health
National Multiple Sclerosis Society, Indiana Chapter
Myasthenia Gravis Foundation, Inc., Indiana Chapter
Indiana Association for Retarded Children, Inc.
Indiana Tuberculosis Association
United Cerebral Palsy of Indiana, Inc.

When it was announced that Danny Thomas would receive the laymen's citation at the annual meeting of the AMA in Chicago, the chairman wrote a letter, through the secretary of the Council on Voluntary Agencies of the AMA, protesting the presentation of such an award because Mr. Thomas represents ALSAC, an unrecognized agency.

The validity of the protest was recognized but it was too late to stop the award, but closer liaison between the board of trustees and the council has been promised in the future.

The members of this commission have given many hours of service to the state medical association and I would like to express my appreciation to each member of the commission for his cooperation during the year.

The members of the headquarters staff have been most helpful — the commission is particularly indebted to Mr. Kenneth Bush and to Miss Eleanor Chapple for their untiring efforts on behalf of all members of this commission and the state association.

NORMAN R. BOOHER, M.D., *Chairman*

Medical Economics and Insurance

The commission met on November 14, 1965, January 13, 1966, March 24, 1966, and April 23, 1966, with good attendance at each meeting.

The first large task of the commission was completion of the proposed Disability Insurance Program. Over two years ago this commission had started a survey which later led to the conclusion that a group insurance plan of this type should be made available to the members of the ISMA, chiefly to supplement the AMA plan or any other insurance already carried. In October, 1965, the House of Delegates approved the program as recommended by this commission to be underwritten by the Continental Casualty Company and to be administered by J. Russell Townsend, Jr.

On November 14, 1965, the commission gave final approval to this program. We had always agreed that the members should be contacted by mail or at meetings, and that only at his own request would a member be solicited personally. Since January 1, 1966, Mr. Townsend has sent out a number of mailings and he and his associates have attended several meetings of hospital staffs and county and district societies. The response has not been very satisfactory.

As of July, only about 300 applications have been received. Approximately 200 of these have policies in effect or policies are now being processed. Several points have been clarified with the Continental Casualty Company. The company will participate in a maximum of $2,100 of monthly benefits or 75% of earnings, whichever is smaller. Overhead expense insurance will not be included in this $2,100 maximum. The application form is being changed slightly to simplify it and clarify these several points. The original agreement was that if at least 1,600 members applied during the charter enrollment period, all eligible members would be insured, but impaired risks and members over 60 would be limited to a monthly benefit of only $100. Because of the slow response, the charter enrollment period has not been closed as yet. It is hoped that the Continental Casualty Company will agree to keep it open at least until after the ISMA Convention in October.

The lack of interest and response to this program could be attributed to one or more of the following factors: 1) This commission was misinformed as to the need for such a program; 2) Concentration of our members on Medicare problems; 3) Difficulties in presenting such a program by mail. This commission will not consider this program very successful unless we receive the 1,600 applications necessary to insure the impaired risks and those over 60 with the minimal $100 monthly benefit. This commission will continue its efforts to launch this Income Replacement Program and hopes to report better progress by October.

Our next concern was malpractice insurance. In September, 1944, the House of Delegates approved The St. Paul Mercury Indemnity Company as the official approved carrier of malpractice insurance for members of ISMA. This was not a true group plan but apparently it was the impression that with this approval, this company would be able to give members a discount in premium rates.

When some objection arose to the continued advertising in our *Journal* by The St. Paul Insurance Companies as the approved carrier for ISMA, the Council introduced Resolution No. 25 in October, 1965, to rescind this approval. The House of Delegates referred this to our commission for further study. Such action was begun in January. We regret that the study has not been completed and that our report and recommendations will be delayed. It was noted in a recent 1966 publication that Indiana is one of 26 states in which The National Bureau of Casualty Underwriters has announced rate increases of 10% to 30% because of "the rising costs of malpractice suits." The increase in Indiana is only 10% but this is of some concern. This commission must continue to pursue the problem of preventing the origin of these liability suits.

The commission has tried to keep informed about taxes and possible tax savings. We do not have exact figures but believe that a very low percentage of our members are enrolled in the "Keogh Act." An effort to make this more attractive and advantageous to the self-employed has been made by introducing an amendment in this current Congress. It seems unlikely that it will even come out of the committee at this time because of the possible need of increasing taxes.

The tax benefits of incorporation still are in doubt. In December, 1965, it was announced that the Internal Revenue Service had given in to physicians who incorporated before 1965 and would let them be treated as corporations for all previous years. The year 1965 and subsequent years would be treated as unincorporated in regard to taxes. Some physicians may be willing to pursue this point and eventually the courts should decide whether or not the IRS regulations should overrule the many state laws that have been enacted.

This commission has begun in 1966 a study of the possible need and desire of members of ISMA for a retirement plan. The AMA plan is limited to participation in the "Keogh Act." In the last five years, many medical organizations — specialty, state and some county societies — have started group investment plans. Most of these are designed to use group buying power of either growth securities or fixed-cost annuities or both, so that the physician can invest on a monthly basis if he desires. These can be independent of the "Keogh Plan" and should result in a forced means of saving for retirement income and a hedge against inflation.

Some of the most successful plans of this type are those sponsored by The Memphis and Shelby County Society, The American Academy of General Practice and the Illinois State Medical Society. Perhaps we in Indiana have been somewhat slow or remiss in considering such plans. We have had presented to us for study "A Variable Pension Plan" such as sponsored by the Indiana State Bar Association. This commission should continue to survey this field and perhaps make positive recommendations in 1967.

For several years ISMA has made available to members a simplified insurance form designed by the Health Insurance Council and first approved by the AMA in 1959. In January this commission learned that a newer and simpler version of this form had been approved by the AMA. When the present supply is depleted, ISMA will make the newer form available. It may be anticipated that additional changes may be made by HIC in this form with Medicare. Dr. Jack W. Hannah has made a special effort to promote a simplification of the form used for military dependents, formerly known as Medicare. This commission sees no reason for this government form to be so complicated and should continue Dr. Hannah's endeavor.

In November three representatives from the Health Insurance Council met with this commission in an appeal for insurance review committees and to consider the possibility of a state review committee. They explained the need for such committees to review questionable health insurance claims submitted by either the insured, the insurer or the physician.

In 1963 this commission introduced a resolution to the House of Delegates to encourage county societies to establish insurance review committees. This commission still recognizes the need for such committees and believes that most cases could and should be resolved by the local committee. However, this commission will endeavor to assist in any problems that cannot be resolved locally. With the advent of Medicare and the resulting problems of usual and customary fees, each county society will surely find it necessary and worthwhile to have a functioning insurance review committee.

In 1962 and 1963, Dr. E. T. Edwards introduced the subject of "Utilization Committees" to this commission. This helped some of us to organize and learn the value of such committees in our local hospitals. This

commission has continued this study and the functions of such committees under Medicare are not especially new to us. It has not been necessary for this commission to help much in 1966 in establishing Utilization Review plans so that Indiana hospitals could participate in Medicare. Mr. Waggener, Mr. Bush, Mr. Amick and Mr. Grindstaff are to be commended for their initiative and for their able counseling of county societies and hospitals throughout the state in regard to participation in Medicare. This commission reminds the members of ISMA that the utilization review function is not only a responsibility of the medical profession, but it is a function that we should direct, control and simplify as much as possible. Otherwise this function will be taken over by an outside group that should not be making decisions for us.

The problems of Public Law 89-97 should come mostly under the functions of the Commission on Governmental Medical Services. However, anything affecting our fees should also interest the Commission on Economics and Insurance. We have continued to study the usual and customary fee concepts, relative value scales, etc. In some areas of the state we have had little or no experience with payment of usual and customary fees under the Resolution No. 26 plan of Blue Shield. Apparently Blue Shield will settle claims for usual and customary fees under Medicare on their actuarial experience in each locality during the first six months of 1966. Very few claims have been processed as of this date. This commission has gone on record as agreeing that members of the ISMA should be encouraged to avoid taking assignments and should continue to bill the patient as before Medicare. The commission should indeed remain alert to these problems of Medicare.

This year has been a very trying time for all of us but especially to the officers and staff of ISMA. We are very grateful to them for their leadership and guidance.

The chairman of this commission wishes to thank the members for the excellent attendance of our meetings and for their generous and able help throughout the past year. The chairman, Dr. Bills and Dr. Hannah are completing six years on this commission. We feel that this commission should continue or even increase its activities to meet the growing problems of the future.

WILLARD T. BARNHART, M.D., *Chairman*
CHESTER A. STAYTON, JR., M.D., *Vice-Chairman*
THOMAS G. HAMILTON, M.D., *Secretary*
R. JAMES BILLS, M.D.
THOMAS J. CONWAY, M.D.
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JACK W. HANNAH, M.D.
ELDRED F. HARDTKE, M.D.
WILLIAM A. JOHNSON, M.D.
JAMES M. LEFFEL, M.D.
JOHN F. LING, M.D.
WILLIAM J. MILLER, M.D.
EDWARD J. PLOETNER, M.D.
W. R. VANDENBOSCH, M.D.
RICHARD WAGNER, M.D.

Inter-Professional Relations

The Commission on Inter-Professional Relations concerned itself with one major subject during the year, which included further investigation of the possibility of establishing an Indiana Association of Professions. A sub-committee, appointed by Dr. Joseph B. Davis, chairman of the commission to carry out this assignment, included Dr. Pierre C. Talbert, chairman, Dr. F. W. Flora and Dr. R. D. Williams.

The association has been investigating this matter since 1963. Dr. Talbert, in an effort to gain additional understanding of the operation, visited the Michigan State Medical Society in East Lansing, Michigan, where he spent the day with Mr. Hugh Brenneman, Executive Director of the Michigan Association, learning of their involvement in the Michigan Association of Professions, which was the initial group developed in this country. As a result of this meeting, and a following sub-committee meeting, letters were written to the Indiana Society of Architects, the Indiana State Dental Association, the Indiana State Bar Association, the Indiana State Teachers' Association, Indiana State Pharmaceutical Association, the Indiana Certified Public Accountants Association and the Indiana Veterans Association.

These groups were asked whether or not they would be interested in pursuing further the establishment of such an organization which would have as its purpose to devise ways and means of better utilizing professional heritages of knowledge and skill for the benefit of society and to create relations between the professions looking toward that end, i.e., to protect, advance and promote professionalism. The results of this mailing indicate that professional groups in Indiana are very much interested in pursuing this matter further.

It is the hope of the commission that next year's commission will continue with further investigation and possible development of such an organization in Indiana. A meeting of the many groups showing interest would seem to be appropriate at this stage.

The commission, as a whole, met once during the year and discussed the Physician-Pharmacist Relation Code, which has been approved by the House of Delegates of the Indiana State Medical Association. Basic work on this code has been completed by the commission. Follow-up liaison with the Indiana Pharmaceutical Association continues in order to consider some of the finer points of the code and to reach agreement on a final draft.

The commission also discussed a possible meeting with the Indiana State Nurses Association and other matters.

JOSEPH B. DAVIS, M.D., *Chairman*
FLOYD A. BOYER, M.D., *Vice-Chairman*
A. WAYNE RATCLIFFE, M.D., *Secretary*
ROBERT H. RANG, M.D.
CHARLES X. McCALLA, M.D.
JOHN W. RIPLEY, M.D.
PAUL HUMPHREY, M.D.
FRANK H. GREEN, M.D.
ROBERT D. WILLIAMS, M.D.
FRED FLORA, M.D.
VIRGIL E. ANGEL, M.D.
PIERRE C. TALBERT, M.D.
ROBERT H. DENHAM, JR., M.D.
A. ALAN FISCHER, M.D.
ROBERT G. HUSTED, M.D.

Medical Education and Licensure

During the past year, the commission continued the work it had outlined for itself previously and began to interest itself in the newly-devised program called "The Indiana Plan for Medical Education."

The Preceptor Program continues to be a very successful project and gradual expansion of this, with maintenance of the high standards, is in view for the next several years. Drs. Kenneth Sherer and George Lukemeyer are mainly responsible for the continuous operation of this program. As the number of students gradually increase during the next few years, so, too, will the number of preceptorships.

After the orientation meeting at the university concerning the Indiana Plan and the DeBakey Law, Dr. John L. Cullison was appointed as association liaison with the university officials for continued contact and help in the further planning and perhaps implementation of the plans at a future date. Much of the work being done now is of necessity formulative, but when concrete details are available, the commission will keep you informed via your county societies.

The commission had our annual meeting with the university faculty heads again this year. These meetings bring about much discussion of various topics and this was no exception. It is a good source for exchange of ideas. Dr. James Johnson has done a creditable job arranging same.

The licensure subsection of the commission has maintained its contacts with that board and with the appointment of Dr. Harry Klepinger to the board, the commission numbers two mutual members. This should help greatly in rapport and clearing away any difficulties which may arise. No formal meeting with the board was held this

year, the feeling being that it was unnecessary.

The commission will continue working for you and expand its scope of activities as much as possible. The members, individually and collectively, are to be thanked for their interest and application to the jobs at hand.

PETER R. PETRICH, M.D., *Chairman*
JOEL SALON, M.D., *Vice-Chairman*
FORREST R. LAFOLLETTE, M.D., *Secretary*
JOHN STERN, M.D.
WALTER VAUGHN, M.D.
JOHN M. PARIS, M.D.
RICHARD A. SNAPP, M.D.
JAMES B. JOHNSON, M.D.
KENNETH E. SHERER, M.D.
GEORGE T. LUKEMEYER, M.D.
JOHN L. CULLISON, M.D.
LEO RADIGAN, M.D.
JAMES R. CARPENTIER, M.D.
HARRY KLEPINGER, M.D.
GLENN W. IRWIN, Jr., M.D., *Ex-Officio*

Aging

The commission met twice during the year, on November 16, 1965 and February 20, 1966. Two major matters under discussion were the Independent Living Survey, as conducted by the Indiana State Board of Health and the commission, and the Home Care Program.

At the first meeting of the commission, Dr. Robert Yoho, Director of the Indiana State Board of Health's Division of Health Education, Records and Statistics, spoke of the need for the commission's support on the Independent Living Study. He said that he hoped physicians in the state could be contacted in order to obtain information on the problems of the aged and the aging in their counties. Dr. Yoho further pointed out that the information gleaned from this survey would provide an educational experience for the next legislature. Hopefully, the survey would convey the idea, Dr. Yoho said, that it is more important to prevent dependency than to take care of these individuals after they have become dependent.

The Commission on Aging, upon approval of the Council, supported the Indiana State Board of Health in this survey and as a way of providing additional information in this report, the statement which the commission has made in connection with the Independent Living Study, and which will be presented to the Governor and to the forthcoming state legislature, is printed below. This statement provides historical background of the Indiana State Medical Association's support of programs in this area.

In connection with this survey, the commission drafted a letter to each county president asking him to appoint a committee on aging with one physician responsible for the reporting of information needed for the survey. In addition to this, each commission member agreed to send to all physicians in his particular county a covering letter with the survey information with the hope of getting as great a return as possible. County societies who had appointed chairmen of committees on aging were also contacted with the request that they help on the survey. Facts and figures on the survey were gathered and analyzed in the late spring and early summer of 1966 so that ample time would be allowed for its final preparation and presentation.

During the February 20 meeting, Dr. B. B. Rosenblatt, member of the commission, brought Mr. David Shelton, Director of Community Health Services in Evansville. Mr. Shelton explained the purposes of the organization, pointing out that the organization had been established as a result of a federal act entitled "The Community Health Services and Facilities Act." It was the commission's feeling that apparently the program in Evansville, especially in the area of home care, had been working most effectively. Mr. Shelton pointed out that some of the programs which have come about because of the interest stimulated by community health services have included home care and coordinated home care to patients residing in their own home; physical therapy and recreation services in nursing homes; in service training programs in nursing homes; work shops and institutes; friendly visitor volunteer programs; central referral and information services; nursing home survey and delivered meals for senior citizens. Federal funds, he said, would not always be available for these projects but he felt that in the near future, voluntary money would be forthcoming to support continuing programs in this area.

One of the additional highlights of the year's activities was a detailed report to the commission by Dr. Andrew C. Offutt, secretary of the Indiana State Board of Health, on Utilization Review Committees — their function, their structure and the need for establishing these review committees as a definite requirement under PL 89-97, otherwise known as Medicare.

In addition, Dr. Glen A. Ramsdell, chairman of the commission, at the request of Dr. Kenneth O. Neumann, president of the association, named Dr. George M. Young as representative of the Indiana State Medical Association to appear October 4 and 5 on a program at Purdue University entitled "Counseling of Older Persons." Dr. Young's role was to discuss the need for physical health counseling. The conference was to be held under the direction of Dr. George E. Davis, Executive Director of the Indiana Commission on Aging and the Aged.

STATEMENT ON INDEPENDENT LIVING SURVEY

In 1961, the Commission on Aging of the Indiana State Medical Association introduced to the House of Delegates of the association four resolutions under the titles of "Independent Living," Resolution 19; "Standard Health and Medical Procedures For County Homes," Resolution 20; "County Medical Society Liaison With Local Group or Groups," Resolution 21 and "Geriatrics Rehabilitation Services," Resolution 22. For your information, copies of these resolutions are printed below.

All resolutions were read and approved by the House of Delegates and with this action, established the fact that physicians of Indiana were taking the leadership role in the growing concern of many to solve the problems of the aged.

Following this action and in response to demands for guidelines on the part of various community groups, the Commission on Aging of the Indiana State Medical Association, under the chairmanship of Dr. Nathan L. Salon, prepared a statement entitled "Organized Home Care for the Sick and the Disabled," which was generally approved by the House of Delegates of the association in October, 1962 and published in the July, 1964 issue of the *Indiana State Board of Health Bulletin.* The tenor of all of these actions accentuated the major theme of making services available at the time when they are needed, and to the degree that they are needed, avoiding overlapping services and duplication with the objective of increasing the individual's capacity for continuing independence in his latter years.

In the 1962 statement of the Commission on Aging, the importance of coordination was specifically emphasized as follows: "This prevents a patient from missing those services which he requires and also eliminates services that are not required in the home care of the particular patient. Further, coordination provides for a schedule by which the individual services may be tendered the patient, thereby eliminating duplication of the services."

Following the passage of Senate Bill 130 in the 1965 legislature, which requested a study on the problems of the aging, physically or mentally handicapped and the chronically ill, the Commission on Aging, as a further endorsement of the bill, wrote to Senator Robert P. O'Bannon and Representative W. T. Sebree in February explaining that they felt the budget request of the Indiana State Board of Health should be granted to conduct the Independent Living Study. The outgrowth of all of these actions, of course, has resulted in the study being conducted in 1966, with the cooperation and

participation of the Indiana State Medical Association. The Commission on Aging cites these facts as evidence of the historical and current interest of the Indiana State Medical Association and the Commission on Aging in continuing efforts to develop state and local programs to meet the problems of the aged in the most effective and economical manner.

Resolution No. 19

Subject: INDEPENDENT LIVING

WHEREAS, in a democracy, it is conceived that an individual should live in dignity and by his own initiative and effort maintains as complete a state of independence as possible throughout his lifetime; and,

WHEREAS, events and situations occur to an individual at different times during his life which if not corrected or relieved result in dependency; and,

WHEREAS, a person's independency may be more nearly assured when only services which are absolutely necessary to restore him to self-sufficiency are made available; and,

WHEREAS, the provision of service and assistance when not absolutely necessary promotes and encourages a continuing and increasing dependency complex;

THEREFORE BE IT RESOLVED, that the Indiana State Board of Health, along with the state medical association and other appropriate official and voluntary agencies, be encouraged to study the causes that lead to the institutionalization of the aged, physically and mentally handicapped and the chronically ill, and to explore ways by which such individuals may be enabled to maintain their independent living status for the longest possible period of time,

BE IT FURTHER RESOLVED, that the State Board of Health and the previously mentioned organizations and groups, upon the basis of their findings, recommend a plan for effecting a program of independent living for the state of Indiana.

Resolution No. 20

Subject: STANDARD HEALTH AND MEDICAL PROCEDURES FOR COUNTY HOMES

WHEREAS, a recent survey of county homes conducted by the State Board of Health and the Governor's Commission on Aging demonstrates that many of these homes do not require a medical examination on admission; and,

WHEREAS, many of these same homes do not provide for periodic medical examinations of their residents and have no well-established policies on medical procedure;

THEREFORE BE IT RESOLVED, that the State Board of Health study these problems for the purpose of developing a medical examination form to be used by county homes with all admissions and,

BE IT FURTHER RESOLVED, that the State Board of Health with the assistance of other appropriate groups, develop and recommend standard health and medical procedures to those responsible for the administration of county homes; and,

BE IT FURTHER RESOLVED, that the State Board of Health should work closely with county commissioners in implementing the above recommended action.

Resolution No. 21

Subject: COUNTY MEDICAL SOCIETY LIAISON WITH LOCAL GROUP OR GROUPS

WHEREAS, there is a continued increase of aged and aging in the population; and,

WHEREAS, more and more individuals and groups are developing concern for the medical problems faced by the senior citizens; and,

WHEREAS, good health or the absence of good health and the availability of medical care are important considerations in relation to any program concerned with the aging; and,

WHEREAS, there is not a single county in the state that does not have within its confines nursing homes and/or county homes, and organized programs concerned with aging;

THEREFORE BE IT RESOLVED, that each county medical society establish a committee or designate one of its members to serve as liaison with these institutions or groups in order that practical and acceptable health and medical care practices may be implemented.

Resolution No. 22

Subject: GERIATRIC REHABILITATION SERVICES

WHEREAS, it is generally agreed that many of the residents of county homes and nursing homes can benefit materially from rehabilitation services; and,

WHEREAS, studies and observation indicates that rehabilitation services are practically non-existent in these institutions; and,

WHEREAS, it is generally believed that best results will be achieved when rehabilitation services are administered by personnel of the institutions who are caring for the residents;

THEREFORE BE IT RESOLVED, that the State Board of Health develop a plan and a procedure by which a continuous program of training in the elementary principles of rehabilitation can be provided for the personnel of county homes and nursing homes;

BE IT FURTHER RESOLVED, that in the event resolutions, "Independent Living"; "Standard Health and Medical Procedures for County Homes"; "County Medical Society Liaison with Local Group or Groups" and "Geriatric Rehabilitation Services" are approved, active support be given to the efforts of the State Board of Health in securing the necessary budget to carry out these activities.

GLEN A. RAMSDELL, M.D., *Chairman*
GEORGE W. WAGONER, M.D., *Vice-Chairman*
BERNARD B. ROSENBLATT, M.D., *Secretary*
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JOHN O. BUTLER, M.D.
RALPH R. PLOUGHE, M.D.
F. S. CROCKETT, M.D.
GEORGE M. YOUNG, M.D.
NATHAN SALON, M.D.
DONALD T. OLSON, M.D.
ANDREW C. OFFUTT, M.D.
WENDELL C. ANDERSON, M.D.

Resolutions

Amendments to the Constitution to be Voted on at French Lick Session, 1966

At the 1965 annual convention at Indianapolis, the House of Delegates adopted the report of the Reference Committee on Amendments to the Constitution and Bylaws, in which the reference committee approved and recommended for adoption the following three amendments to the Constitution: (Words or sections added are italicized).

(1). Delete paragraph No. 3, Article IX, Sec. 5, which reads as follows: "The alternate Councilor shall not have the power of discussion if the regularly elected Councilor is present."

(2). **Article V** — To be amended by adding after the word, "Delegates" and before the word, "elected" the following: "or their designated alternates," making this read, "(1) Delegates, *or their designated alternates,* elected by the component county societies"; and (2) be amended by adding after the word "Councilors" the following: "or their designated alternates" making it read "(2) *the Councilors, or their designated alternates.*"

(3). **Article VI** — The first line to be amended to read as follows: "The Council shall consist of (1) the Councilors with *power to vote, and their duly elected alternates, without power to vote, except in the absence of his Councilor.*" This will then make Article VI read as follows: "The Council shall consist of (1) the Councilors *with power to vote, and their duly elected alternates, each of the latter without power to vote, except in the absence of his Councilor; and (2) ex officio the President. . . .*"

Resolution No. 1

Introduced by: ST. JOSEPH COUNTY MEDICAL SOCIETY
Subject: CHANGES IN MEDICAL LICENSURE ACT OF INDIANA

WHEREAS, there has been for years, and still is, a shortage of interns in Indiana and, also, a shortage of general practitioners and certain specialists in some areas of the state and,

WHEREAS, the Medical Licensure Act restricts and discourages interns, residents and teaching fellows and general practitioners and specialists from coming to Indiana from other states which tends to reduce the quality and the proper number of physicians and educators,

NOW THEREFORE BE IT RESOLVED, that the St. Joseph County Medical Society requests that the Medical Education and Licensure Commission, along with the Legislative Commission of the Indiana State Medical Association study, propose, and vigorously support changes in the Medical Licensure Act at the meeting of the Indiana Legislative Assembly in 1967 to allow interns, residents, teaching fellows and qualified M.D.'s to more easily secure license in Indiana including the consideration of offering the necessary examination more than once a year, and to restudy the advisability of temporary licenses to qualified doctors of medicine.

Resolution No. 2

Introduced by: THE MARION COUNTY MEDICAL SOCIETY
Subject: AMENDMENT OF THE CONSTITUTION AND BYLAWS TO PROVIDE ADDITIONAL CATEGORIES OF MEMBERSHIP

WHEREAS, organized medicine should embrace every eligible physician, and,

WHEREAS, increases in the amount of the annual dues of the Indiana State Medical Association, the American Medical Association and some county medical societies have been effected, and,

WHEREAS, there are physicians in various governmental and teaching situations whose income is restricted and who have not become members of these medical groups because of the total expense,

NOW THEREFORE BE IT RESOLVED, that the House of Delegates of the Indiana State Medical Association establish membership categories for such physicians by amendment of the Constitution and Bylaws and require payment by them of a lesser amount of annual dues than is required of other active members.

Resolution No. 3

Introduced by: THE MARION COUNTY MEDICAL SOCIETY
Subject: TUBERCULIN TESTING OF PRE-SCHOOL CHILDREN

WHEREAS, eradication of tuberculosis long has been a goal of the medical profession, and

WHEREAS, a high percentage of the children in some elementary schools, particularly in urban areas, have not been tested for tuberculosis, and

WHEREAS, appeals to parents of some of the children voluntarily to arrange for them to be tested for tuberculosis have not achieved the desired results, and

WHEREAS, tuberculosis cannot be eradicated as long as such sources of infection are allowed to exist, and

WHEREAS, it is generally accepted by specialists in the field that tuberculin testing of children is the most effective way to find undetected cases,

NOW THEREFORE BE IT RESOLVED, that the Commission on Legislation of the Indiana State Medical Association be directed to seek legislation which will make it unlawful for any child in Indiana to enter first grade who cannot, or will not, provide written evidence that he has been tested for tuberculosis.

Resolution No. 4

Introduced by: THE MARION COUNTY MEDICAL SOCIETY
Subject: AMA SUPPORT OF THE COLLEGE OF AMERICAN PATHOLOGISTS

WHEREAS, the Department of Justice has recently filed a suit at law against the College of American Pathologists, and

WHEREAS, the points at issue involve the ethics of all physicians, and

WHEREAS, this appears to be the beginning of harassment of the entire medical profession,

NOW THEREFORE BE IT RESOLVED, that the officers and delegates of the Indiana State Medical Association be requested to present a suitable resolution to the House of Delegates of the American Medical Association requesting the American Medical Association to give the College of American Pathologists support in every appropriate way.

Resolution No. 5

Introduced by: THE MARION COUNTY MEDICAL SOCIETY
Subject: CORRECTION OF THE PRACTICE OF THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS OF CERTIFYING HOSPITALS WHICH HAVE NON-PHYSICIAN LABORATORY DIRECTORS

WHEREAS, approval of a hospital by the Joint Commission on Accreditation of hospitals has become a mark of prestige, and

WHEREAS, the American Medical Association supports Joint Commission on Accreditation of Hospitals with finances and manpower, and

WHEREAS, the Joint Commission on Accreditation of Hospitals recently has certified hospitals which have laboratory directors who are not physicians, and

WHEREAS, the Indiana State Medical Association and the American Medical Association repeatedly have recognized the

practice of clinical pathology as the practice of medicine,

NOW THEREFORE BE IT RESOLVED, that the officers and delegates of the Indiana State Medical Association be requested to present a suitable resolution to the House of Delegates of the American Medical Association seeking to correct this practice.

Resolution No. 6

Introduced by: MARION COUNTY MEDICAL SOCIETY

Subject: REVISION OF COUNCILOR DISTRICTS OF THE INDIANA STATE MEDICAL ASSOCIATION

WHEREAS, present councilor districts of the Indiana State Medical Association are based on certain geographical boundaries and, thus, are not representative of the membership numerically, and,

WHEREAS, the Council, which has full charge and control of all property of the association and which is the governing body of the organization between sessions of the House of Delegates, should represent the membership on a more equitable basis, and,

WHEREAS, as present districts are defined, one councilor represents as few as 138 members and another as many as 1,127, as indicated in the official membership report of the association as of December 31, 1965, and,

WHEREAS, seven of the thirteen councilors represent a total of 1,300 members and the other six represent a total of 3,096 members, again revealing inequity of representations, and,

WHEREAS, this inequitable distribution of membership in the councilor districts also is reflected in the various commissions of the association and in the Board of Directors of Blue Shield, whose members, except for the members-at-large, are chosen by councilor districts, and,

WHEREAS, the Constitution and Bylaws of the association provides that there shall be thirteen councilors but does not define the councilor districts, and the definition of the districts is the duty of the House of Delegates,

NOW THEREFORE BE IT RESOLVED, that the House of Delegates of the Indiana State Medical Association redefine the councilor districts so that each councilor represents approximately 300 members of the association, except that in any county in which the medical society has a large membership, each 300 members shall constitute a district and one group of officers shall be elected to serve the combined districts, and,

BE IT FURTHER RESOLVED, that councilor districts shall be redefined as follows:

BE IT FURTHER RESOLVED, that implementation of this resolution shall be accomplished in the following manner:

1st District. The present councilor shall continue to serve until his term of office expires, in 1968, at which time the district shall reorganize and a new councilor shall be elected.

The alternate councilor, to be elected from the present district in 1967, shall continue until his term of office expires, in 1969. His successor shall be elected by the reorganized district.

2nd District. The present councilor shall continue to serve until his term of office expires, in 1969, at which time the district shall reorganize and a new councilor shall be elected.

The alternate councilor, whose term of office expires in 1968, shall continue to serve until 1970, when his successor shall be elected by the new district.

3rd District. The present councilor shall continue to serve until his term of office expires, in 1967, at which time the district shall reorganize and a new councilor shall be elected.

The alternate councilor shall continue to serve until his term of office expires, in 1968, at which time his successor shall be elected by the reorganized district.

4th District.

5th District.

7th District. The present councilors from the 4th, 5th and 7th districts shall continue to serve until their terms of office expire, in 1968, at which time the districts shall reorganize and elect new councilors.

The alternate councilor from the 4th district shall continue to serve until 1969, when the reorganized district shall elect a new alternate councilor.

The alternate councilor from the 5th district shall continue to serve until his term of office expires, in 1969, at which time the reorganized district shall elect a new alternate councilor.

The alternate councilor from the 7th district shall continue to serve until his term of office expires, in 1969, at which time the reorganized district shall elect a new alternate councilor.

6th District. The present councilor shall continue to serve until his term of office expires, in 1967, at which time the district shall reorganize and a new councilor shall be elected.

The alternate councilor shall continue to serve until his term of office expires, in 1969, at which time the reorganized district shall elect a new alternate councilor.

8th District. The present councilor shall continue to serve until his term of office expires, in 1969, when the district shall reorganize and a new councilor shall be elected.

The alternate councilor shall continue to serve until 1970, at which time the reorganized district shall elect a new alternate councilor.

9th District. The present councilor shall serve until his term of office expires, in 1967, at which time the district shall reorganize and elect his successor.

The alternate councilor shall serve until his term of office expires, in 1968, at which time the reorganized district shall elect his successor.

10th District. The present councilor shall serve until his term of office expires, in 1968, at which time the district shall reorganize and elect his successor.

The present alternate councilor shall serve until his term of office expires, in 1969, at which time the reorganized district shall elect his successor.

11th District. The present councilor shall serve until his term of office expires, in 1969, at which time the district shall reorganize and elect his successor.

The present alternate councilor shall serve until his term of office expires, in 1970, at which time the reorganized district shall elect his successor.

12th District. The present councilor shall serve until his term of office expires, in 1967, at which time the district shall reorganize and elect his successor.

The present alternate councilor shall serve until his term of office expires, in 1968, at which time the reorganized district shall elect his successor.

13th District. The present councilor shall serve until his term of office expires, in 1968, at which time the district shall reorganize and elect his successor.

The present alternate councilor shall continue to serve until 1969, at which time the reorganized district shall elect his successor.

This plan will provide for 13 councilors at all times. Four will be elected in 1967; six in 1968 and three in 1969. Thus, in 1969, all councilors will represent the new districts as defined by this resolution.

BE IT FURTHER RESOLVED, that each newly organized district shall determine the proper procedure for it to follow in election of its representative on the Blue Shield Board of Directors.

BE IT FURTHER RESOLVED, that when the membership in any district or county society arrives at a point where 200 or more members are not represented by a councilor on the basis of one councilor for each 300 members, the House of Delegates shall again reconsider defining councilor districts.

1st District

Posey	10
Vanderburgh	236
Warrick	7
Spencer	4
Perry	9

Gibson	15
Pike	4
Knox	38
Daviess-Martin	20
Total Members	343

2nd District

Parke-Vermillion	23
Putnam	15
Vigo	120
Clay	11
Sullivan	15
Greene	16
Owen-Monroe	61
Hendricks	22
Morgan	18
Total Members	301

3rd District

Dubois	24
Lawrence	24
Orange	9
Harrison-Crawford	11
Floyd	37
Clark	40
Scott	4
Washington	7
Jackson-Jennings	24
Bartholomew-Brown	46
Decatur	11
Jefferson-Switzerland	28
Dearborn-Ohio	20
Ripley	9
Total Members	294

4th, 5th and 7th Districts

Marion	1,058

6th District

Johnson	29
Shelby	20
Hancock	22
Rush	14
Fayette-Franklin	16
Jay	15
Randolph	21
Henry	39
Wayne-Union	68
Total Members	244

8th District

Madison	101
Delaware-Blackford	124
Grant	70
Wells	37
Adams	14
Total Members	346

9th District

Porter	32
Starke	7
Jasper	7
Newton	5
White	12
LaPorte	100
Pulaski	5
Benton	9
Fountain-Warren	15
Tippecanoe	125
Montgomery	27
Total Members	344

10th District

Lake	440

11th District

LaGrange	7
Huntington	25
Marshall	27
Carroll	8
Clinton	20
Noble	17
Wabash	25
Fulton	11
Miami	14
Boone	19
Hamilton	24
Whitley	17
Kosciusko	19
Cass	37
Howard	68
Tipton	11
Total Members	349

12th District

Allen	294
DeKalb	23
Steuben	14
Total Members	331

13th District

St. Joseph	236
Elkhart	108
Total Members	344

Resolution No. 7

Introduced by: VANDERBURGH COUNTY MEDICAL SOCIETY

Subject: COMMUNITY DUMPS

WHEREAS, the Indiana State Health Department is advocating that disposal of community waste products in open dumps be discontinued and supplanted by sanitary land fills, or by incineration, and

WHEREAS, this is desirable not only for health and hygienic reasons, but also for esthetic ones,

NOW THEREFORE BE IT RESOLVED that ISMA endorse the state health department position regarding community dumps, and,

BE IT FURTHER RESOLVED, that our officers and Commission on Legislation cooperate in promoting enactment of necessary legislation to accomplish this.

Resolution No. 8

Introduced by: VANDERBURGH COUNTY MEDICAL SOCIETY

Subject: CHANGE IN PL 89-97

WHEREAS, the Medicare program of payment for professional services by physicians provides, as an alternative to assignment of benefits, that a *receipted* bill can be utilized by a beneficiary to collect his reimbursable portion, and

WHEREAS, the necessity of first raising the full amount in cash may entail a very real hardship for many such patients, and this, in turn, unjustly generates criticism largely directed toward the physician, who did not devise this arrangement,

NOW THEREFORE BE IT RESOLVED, that ISMA directs its officers to attempt to persuade the responsible government agencies to change the mechanics of reimbursement for professional services under Medicare so that a valid statement for professional service rendered may be utilized to obtain the payment, with appropriate measures to prevent abuses, and

BE IT FURTHER RESOLVED, that our delegates to AMA work toward similar efforts by the American Medical Association.

Resolution No. 9

Introduced by: GRANT COUNTY MEDICAL SOCIETY

Subject: COMMENDATION OF PROPOSED CURRICULUM STUDY AND EXPANSION, I. U. SCHOOL OF MEDICINE

WHEREAS, the medical profession has the obligation to the public to provide competent and sufficient medical care, and

WHEREAS, due to many reasons in the United States there now exists an increasing deficit in the availability to the public of practicing physicians, and

WHEREAS, in the state of Indiana there has been a failure to maintain this ratio of physicians to the patients in comparison with neighboring states as well as in many others in spite of the increased number of medical students graduating from the one medical school in Indiana, and

WHEREAS, competent physicians in all categories of endeavor, both specialists and particularly general practitioners, should be encouraged by all proper means to remain or to come to Indiana, and

WHEREAS, a number of proposals have been placed before a committee of the state legislature hopefully to deal with these problems, and

WHEREAS, the proposal presented by the dean and faculty of Indiana University Medical School is being considered as one

means of accomplishing these objectives, the following advantages of this proposal are noted.

1. It would utilize existing institutions, facilities and physicians over the entire state, thus potentially involving all interested physicians in the teaching and training of doctors, thereby appropriately stimulating and improving the existing professional endeavor in the broadest possible manner.
2. By its proposed utilization of modern communications techniques and devices, savings in money can be anticipated in accomplishing a prompt increase in medical training in the state.
3. By its imagination and pioneering concept, the state of Indiana already has received national and international academic and public recognition so that the implementation of such a program would place Indiana in the forefront of the rapidly evolving field of medical education, thereby attracting both students and faculty of quality from the widest sources.
4. By improving and altering the scope of the undergraduate medical curriculum and by increasing the graduate medical training potential for the state, physicians schooled in Indiana as well as others may be attracted to come to or remain in Indiana to serve its citizens.
5. While this proposal offers prompt potential for implementation with almost immediate results, it does not eliminate but rather encourages and could subsidize the ultimate development of additional medical schools in the state whenever and wherever this potential may be truly realized,

NOW THEREFORE BE IT RESOLVED, that the Indiana University Medical School dean and faculty be commended for the far-sighted, revolutionary and stimulating curriculum study and expansion proposal they have laid before the state legislature as one means of accomplishing these objectives, and that the Indiana State Medical Association offer its services in supporting this and any other proper effort directed toward improving the quality and availability of medical care to the citizens of our state.

Resolution No. 10

Introduced by: LAPORTE COUNTY MEDICAL SOCIETY

Subject: MEDICAL DIRECTOR, DEPARTMENT OF CORRECTION

WHEREAS, the State Board of Correction of the state of Indiana has within its jurisdiction the health of approximately 7,500 inmates; and

WHEREAS, the operation of the medical department of these institutions has shown certain deficiencies in selection of medical personnel and procurement of medical supplies and equipment

NOW THEREFORE BE IT RESOLVED, by the LaPorte County Medical Society that the medical needs of inmates of the institutions of the State Board of Correction of Indiana would be better met by the establishment of a medical department under the direction of a licensed physician within the State Board of Correction; such department having authority for the selection and direction of personnel, procurement of medical supplies and equipment; and

BE IT FURTHER RESOLVED, that this resolution be formally transmitted to the Indiana State Medical Association for consideration by the House of Delegates at the next session.

Scientific Exhibits

RICHARD B. HOVDA, M.D., *Evansville, Chairman*

RADIOGRAPHIC CHANGES IN RHEUMATOID ARTHRITIS

Exhibitor: T. R. Marshall, M.D., Louisville, Ky.
Co-exhibitor: David H. Neustadt, Louisville, Ky.
Attendant: T. R. Marshall, M.D.

Soft tissue, bone, and vascular changes occurring in rheumatoid arthritis will be demonstrated by x-rays and arteriograms. Rheumatoid arthritis is a systemic disease of connecting tissue involving many organs and structures, other than bone and joints. A chronic synovitis of the tendon sheaths and joints. Hyperemic and occlusive patterns are found, with the majority of the vascular changes being occlusive. A radiologic diagnosis is possible more often than is realized and is particularly valuable when clinical manifestations are atypical.

ANXIETY OR DEPRESSION

Exhibitor: Seymour Diamond, M.D., Chicago, Ill.
Co-exhibitor Edwin Feldman, M.D., Chicago, Ill.
Attendant: Seymour Diamond, M.D.

In this exhibit, groupings are shown that will help differentiate endogenous depression from anxiety neurosis complicated by secondary depressive symptoms. The elucidation of these symptoms is the result of accurate global observation of the patient by the physician, medical examination to rule out physical disease and careful critical history taken. In most instances, the generalist or internist can most adequately diagnose and treat these types of cases.

A differentiation between a primary illness of mental depression and symptoms of depression associated with psychoneurosis is important since the therapeutic approach may differ greatly. Anxiety and depression are usually present in varying degrees. The more conspicuous the anxiety, the more likely a basic psychoneurosis, while predominating depression often indicates an affective disorder.

Endogenous depression is helped by antidepressant drugs, but anxiety may be aggravated by *some* of these drugs. Conversely, anxiety may be aided by tranquilizing drugs but depression deepened, even to the possibility of suicide.

INDIANA FLYING PHYSICIANS ASSOCIATION

Exhibitor: Indiana Chapter, Flying Physicians Association
Attendants: Louis Byrne, M.D., Robert Reed, M.D., Robert Butterfield, M.D., Dan L. Urschel, M.D.

MAGNESIUM DEFICIENCY IN SURGICAL CONDITIONS

Exhibitor: Donald W. Meier, M.D., Bluffton
Co-exhibitor: Charles E. Jackson, M.D., Bluffton
Attendants: D. W. Meier, M.D., C. E. Jackson, M.D.

This exhibit emphasizes the importance of magnesium in surgical problems. Methods of determining magnesium levels are compared. Abnormal magnesium levels are associated with long term parenteral therapy, severe diarrhea or prolonged vomiting, chronic alcoholism, diuresis after oliguria, pancreatitis and other conditions in which magnesium therapy can be important.

INDIANA STATE ASSOCIATION OF MEDICAL ASSISTANTS

METASTATIC WILMS' TUMOR: THERAPY WITH SURVIVAL

Exhibitors: Robert A. Garrett, M.D., John P. Donohue, M.D., Thomas A. Arnold, M.D., Indiana University Medical Center, Indianapolis
Attendants: Exhibitors as mentioned above

Six patients are reported who had metastatic lung tumors following nephrectomy for Wilms' tumor. These metastases were treated with radiotherapy and in some cases followed by surgical excision and chemotherapy. One case had three separate metastatic lung tumors treated with radiation followed by surgery, and she is presently free of tumor and has been so for the past two years.

These cases are presented in detail and documented radiologically and pathologically where possible.

These cases illustrate the value of pursuing isolated metastatic lesions to the lung, following nephrectomy for Wilms' tumor, with the various modalities of treatment at our disposal.

MICROSURGICAL TECHNIQUE FOR THE CATARACT INCISION

Exhibitor: Herbert P. Hargett, M.D., Department of Ophthalmology, Clark County Memorial Hospital, Jeffersonville
Attendant: June Cleveland, R.N., Surgical Assistant

A method for making a planned, measured cataract incision and a precise and exact procedure for suturing it, utilizing the operating microscope, will be presented.

The microscope enables the incision to be controlled within 0.1 to 0.2 m.m., and the incision to be closed with precise apposition.

The main advantages of the technique, utilizing the operating microscope, to be illustrated in the exhibit by enlarged color photographs, line drawings and screen projected color slides with tape recorded descriptions are:

1. Finer control in tissue handling and inspection.
2. Point cautery to control bleeding with minimal electrocoagulation.
3. Accurately measured combined vertical-bevel type incision.
4. Accurate point apposition of cornea to sclera.
5. Precise placement of forceps and needles in cornea and sclera borders.
6. Uniformity of management and tying of sutures.

The photography of exceptionally high quality was done by Mr. Norris Mode, professional photographer, with a Hasselblad camera.

DESIGN FOR LIVING

Exhibitor: Logansport State Hospital, Logansport

This exhibit attempts to show the results of an integrated program consisting of various modalities which have been designed specially for assisting and guiding the mentally ill patient in his process of emergence from a negative state of personal and social existence to a life of meaningful relationships within his family and community surroundings. The course of hospitalization is directed toward the goal of making the patient ambulatory and ready for discharge in the shortest time possible.

The specific modalities selected can be briefly described as follows: (1) Assessments of the whole individual and deter-

mination of appropriate medical and psychiatric therapy. (2) Effective coordination of all necessary paramedical facilities. (3) Creation within the hospital (wards, dining rooms, etc.) of an environment which closely resembles family and community life. (4) Programs of remotivation where varied and definitive treatment programs such as occupational therapy, music therapy, art therapy, recreational therapy, etc., are located in a modern and fully staffed Activity Center Building. Facilities for vocational rehabilitation are available as follows: farming, gardening, furniture design and construction, etc. (5) A program designed for stimulating self-improvement and reintroducing chronic schizophrenics to everyday modern life as outlined by the hospital improvement program; e.g., resocialization, learning to use appliances, family style living, etc. (6) Use of community facilities such as parks, swimming pools, etc. (7) Statistical data covering these programs which started eight years ago will be presented. The main theme of this exhibit is to show how many mental hospitals can re-orient and coordinate their existing facilities for establishing a design which will effectively help a mental patient in returning to the community.

ANTERIOR CERVICAL FUSION FOR CERVICAL ARTHRITIS

Exhibitor: Karl L. Manders, M.D., Indianapolis
Co-exhibitor: John S. Marks, Jr., M.D., Indianapolis
Attendants: Dr. Manders and/or Dr. Marks

This exhibit illustrates a relatively new surgical procedure which has been used over the past year and one-half for the relief of intractable head and neck pain and certain individuals who have cervical spondylosis.

With careful limitation and selection of the patient, it has been possible to improve the clinical state of those individuals having headache as well as neck and arm pain secondary to arthritis in over 90% of the patients operated upon.

The exhibit demonstrates pre- and post-operative x-rays as well as listing the indications for this type of surgery, the results and the complications resulting and some technical details as well.

The operation itself is quite simple, does not require a cast and the patient is usually discharged a week or ten days following the surgical approach.

SERUM ENZYME PATTERNS AS DIAGNOSTIC AIDS

Exhibitor: Harley P. Palmer, M.D., Department of Pathology, Methodist Hospital, Indianapolis
Co-exhibitors: Charles R. Ellis, M.D., Carole A. Marks, M.T. (ASCP), Department of Pathology, Methodist Hospital, Indianapolis
Attendants: C. R. Ellis, M.D., and/or Carole Marks, M.T.

Typical cases, charts, and graphs are used in this exhibit to illustrate the diagnostic use and possible therapeutic implications of serum enzymes.

Each body organ has its own normal qualitative and quantitative enzyme content, and cell damage in an organ is reflected by the resultant enzyme distribution in the serum.

Repeated enzyme determinations for a period of several days is a diagnostic aid in differentiating myocardial infarction from angina pectoris and from other diseases.

Enzyme levels are valuable in guiding therapy and predicting prognosis in conditions such as recurrent myocardial infarction and hepatitis.

Although the CPK is the most reliable single enzyme determination for indicating myocardial damage, no one enzyme is specific for any disease. Consequently, a variety of enzyme determinations should be employed whenever possible.

DIAGNOSIS AND TREATMENT OF PHEOCHROMOCYTOMA

Exhibitor: Edward L. Moorhead, II, M.D., Detroit, Mich.
Co-exhibitors: Joseph P. Elliott, M.D., John R. Caldwell, M.D., Emerick Szilagyi, M.D., Silvio A. Salerna, M.D., A. R. Morales, M.D., Henry Ford Hospital, Detroit, Mich
Attendants: Edward L. Moorhead, II, M.D., Joseph P. Elliott, M.D.

The importance of diagnosing pheochromocytoma cannot be overemphasized, for untreated patients have a very high mortality as compared to a generally good prognosis in those in whom the tumor has been surgically removed. It has been estimated that more than 1,000 cases of this tumor occur annually in the United States, a large proportion of which are not detected during life.

This exhibit presents a diagnostic approach to the hypertensive patient aimed at discovering the maximum number of these neoplasms. The first panel presents the symptoms and physical findings sometimes seen in this tumor. Panel two is devoted to a demonstration of pharmacological and chemical screening tests. Catecholamine metabolism is schematically presented in relation to diagnostic tests. The third panel consists of a demonstration of the various radiological proceedings used in the diagnosis of this tumor. Panel four combines a short, soundless movie on the surgical removal of pheochromocytoma with illustration of the necessary preoperative and operative precautions. The final panel demonstrates the pathological findings, including electron microscopy. In addition, attention is drawn to many of the unusual aspects of this tumor, including its association with Cushing's syndrome, thyroid carcinoma, various neuroepidermal disorders and its familial occurrence.

PELGER-HUET ANOMALY: A FAMILIAL HEMATOLOGIC ENTITY

Exhibitors: W. P. Loh, M.D., Chief Pathologist; Mrs. Deane McBride, M.T., (ASCP), Chief Med. Technologist, Methodist Hospital of Gary, Inc., Gary
Attendants: Exhibitors or a well informed person to be designated later.

Pelger-Huet anomaly involves the abnormal appearance of white blood cells, particularly the neutrophils. The abnormal appearance involves the nuclear chromatin pattern and the reduced segmentation of the nucleus. It was first described by Pelger in 1928 and by Huet in 1931. Since then, at least 200 cases have been observed among central and western Europeans. The condition occurs rarely in Orientals and Negroes and was seldom reported in this country.

This exhibit describes 15 cases in a Mexican family, the largest number of cases ever reported in a single family. Charts and color photographs are used for the illustration. This condition is generally benign, and is believed to be a Mendelian dominant defect.

HIGHWAY AND STREET DEATHS

Exhibitors: W. P. Loh, M.D., Chief Pathologist; A. S. Williams, M.D., Coroner, Office of Lake County Coroner, Gary
Attendants: Exhibitors as mentioned above

Motor vehicle accidents caused nearly 50,000 deaths in 1965. The total number of deaths, as far as could be recorded in this country, passed the 1,000,000 mark nearly six years ago. Until something can be done to reverse the upward trend, highway and street accidents will continue to be the leading cause of death for our young citizens who are in the most productive period of life for the elevation of our national economy. The highway and street deaths have caused great concern of our medical profession and the general public as well. This is a timely subject for us to present.

This exhibit consists of color photographs and illustrations which demonstrate the

various types of fatal injuries caused by motor vehicle accidents on highways and streets. In some of the cases the exhibit also discusses the case history, investigation at scene, cause of the accident and possible preventive measures. This presentation represents a part of the motor vehicle accidents recently handled by the Lake County Coroner's Office. The pertinent statistics are given.

Remarks: Motor vehicles include both automobiles and motorcycles.

ABNORMALITY OF WHITE BLOOD CELLS IN MENTAL ILLNESS

Exhibitors: W. P. Loh, M.D., Pathologist; A. Metzcus, C. T., Cytotechnologist, Beatty Memorial Hospital, Westville

Attendants: The exhibitors or Mrs. Deane McBride, M.T., (ASCP)

In recent literature, abnormality of plasma proteins and abnormality of lymphocytes have been repeatedly described in mental patients, especially the schizophrenics. Kamp in 1962 reported a pattern of nuclear changes seen in the lymphocytes of chronic schizophrenics. Other investigators have reported similar findings, including the abnormal bone marrow in schizophrenics.

This exhibit describes our investigation on thirty mentally ill patients and five normal subjects serving as controls. The patients belong to four categories of mental diseases. Their mental diagnoses were kept secret until the results had been given by the chief investigator. In such blind study, using several staining technics for their blood smears, the abnormal findings were analyzed and the specificity of the abnormal findings in schizophrenia studied. Thus far, the degree of specificity in schizophrenia does not seem to be high. In attempt to search for possible plasma protein factors and to reproduce the abnormality, preserved plasma specimens obtained from a few positive cases were allowed to react with the leukocytes of selected normal subjects. Charts and color photographs are used to illustrate our results.

Remarks: This study was supported by a grant from the Department of Mental Health, State of Indiana

SEX KILLINGS

Exhibitors: W. P. Loh, M.D., Chief Pathologist; A. S. Williams, M.D., Coroner, Office of Lake County Coroner, Gary

Attendants: Exhibitors as mentioned above

Lake County has a population approaching 600,000 and includes the Gary, Hammond and East Chicago area. In recent years the Lake County Coroner's Office has handled 250 to 450 deaths per year. Approximately 15% of the cases were homicidal deaths which were principally caused by bullet or stab wounds. The sex murder cases were comparatively rare, amounting to one case per year. However, the sex killing incidence has an upward trend and the recent cases have caused great concern of our medical profession and the general public as well.

The purpose of this exhibit is not to publicize the sex killings but to point out the patterns of fatal attacks and the difficulties involved in investigation. Illustrations and color photographs without identification of the victims are used to demonstrate the types of injuries and the procedures needed in investigation. The exhibit covers four usual and one unusual case of sex killing. The unusual case is presented in more detail. Experience learned in these cases is needed for prevention of future sex killings.

Remarks: A part of the material presented in this exhibit was previously presented in a paper read at the Annual Meeting of the National Association of Coroners, July 26 through July 30, 1966, Miami Beach, Florida.

SELECTION OF EARLY THERAPY IN BACTERIAL INFECTIONS

Exhibitor: Malcolm L. Barnes, M.D., Louisville, Ky.

Attendants: Harvey Scribner, Lois Hofmann

With the appearance of so many possible therapeutic agents and with ever-increasing numbers of antibiotic-resistant bacteria, it has become more and more necessary to identify the organism responsible for the disease process, and to check the sensitivity of this organism to the many possible therapeutic agents.

The physician who first sees the patient with a bacterial infection may quite often, by exercising his diagnostic ability and by using a few simple procedures, proceed immediately to a program of therapy.

The physician should always attempt to prepare a primary smear in bacterial infections. Examination of the smear in his own office or an immediate report by the laboratory may prove an invaluable aid in determining what organism is causing the trouble and the selection of an effective drug.

This exhibit is to remind the practitioner of the primary classification of gram positive and negative cocci, diplococci, groups, chains, and of rods, with or without spores, so that he can put these simple findings together with his clinical observations to render early emergency treatment for bacterial infections.

AUTOMATED MULTIPHASIC HEALTH SCREENING

Exhibitor: Malcolm L. Barnes, M.D., Louisville, Ky.

Attendants: Harvey Scribner, Lois Hofmann

"Automated multiphasic health screening" refers to the use of batteries of automated laboratory examinations for a more complete health evaluation. A battery of tests may detect pre-symptomatic phases and functional manifestations of disease before significant organic changes occur.

Not only does properly controlled automated equipment give us better quality performance but whole batteries of examinations can be performed in a fraction of the time, and at about the cost of two or three manual procedures.

Preventive medicine begins with a health evaluation on a periodic basis, and multiphasic health screening makes a more complete health evaluation possible.

INDIANA PHARMACEUTICAL ASSOCIATION

Exhibitor: Indiana Pharmaceutical Association

Attendants: James D. Hawkins, R. Ph., H. George DeKay, R. Ph.

The Drug Abuse Control Amendments of 1965 and their effect on the practice of medicine and pharmacy will be emphasized. New trends in record keeping and related pharmaceutical services will be portrayed.

INDIANA ACADEMY OF GENERAL PRACTICE

Exhibitor: Indiana Academy of General Practice

Attendants: Mrs. Therese Koras, Ross L. Egger, M.D., William Strecker, M.D.

DIFFERENTIAL DIAGNOSIS AND TREATMENT OF SYPHILIS

Exhibitor: Indiana State Board of Health

Attendants: Robert Humphrey, in charge; Claude Brozzo, Robert Ryan

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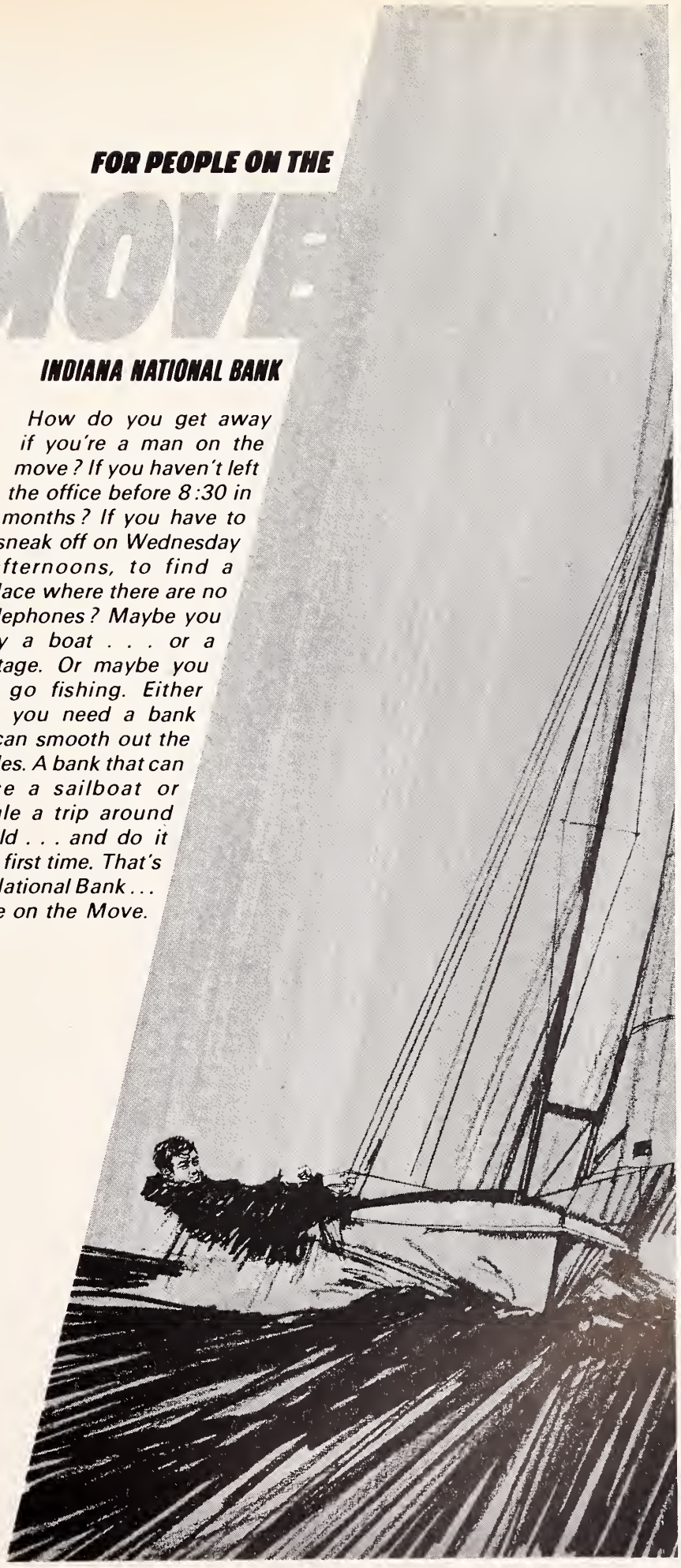

The Heart of a Training Program*

CHARLES T. GREGORY, M.D.†
Dallas, Texas

THIS is the first meeting of residents in Orthopaedic Surgery, past and present, honoring Dr. Garceau's emeritus status. Though this meeting is unique for that reason, it is more significant that this group of men and their wives have been meeting annually, for many years, and each such meeting is better attended than the last. What accounts for the remarkable enthusiasm with which the Riley Orthopaedic Alumni attend its meeting so regularly? What nostalgia draws them? Or is it nostalgia? Perhaps an examination of the beginning and growth of the Riley Orthopaedic Program, and of its parent, the Indiana University School of Medicine, may provide an answer to this question.

From information made available by Dean Irwin, it appears that a whole series of medical schools and colleges emerged upon the scene in Indiana between the years of 1874 and 1908. Some were located in Indianapolis, others in Fort Wayne and Bloomington. Some were attached, though tenuously, to Indiana University, Butler University or Purdue University.

There appears to have been a number of mergers beginning in 1905, when the Indiana University School of Medicine, and the State College of Physicians and Surgeons united under the name of the former. In 1909 the state legislature formally charged the trustees of Indiana University to conduct a medical school in Marion county, and thereafter, the Indiana University School of Medicine remained the only medical school in the state. This date is remarkably parallel to the renowned Flexner Report, which was then in preparation and was to be published in 1910.

Master of All

In the early medical schools of that era, medicine was medicine, surgery was surgery, obstetrics was as much mid-wifery as obstetrics, and the doctor was the master of them all. Progress and expanding knowledge soon produced narrower interests, and voluntary restrictions in practice. At first such restrictions were informal, but later they became highly formalized, leading to the present state of specialization and to certification boards.

Coincidentally, a large national organization, "The Shriners", and a group of Indiana's citizens, seeking to memoralize their Hoosier Poet, James Whitcomb Riley, discovered the universal and disarming appeal of the crippled child and the need of facilities for their care. In 1924, the James Whitcomb Riley Hospital for Children was opened, and that same year the first of a chain of Shrine Hospitals for Crippled Children was opened in Shreveport, Louisiana. I know not which hospital was actually first, nor does it matter. Each was to play a profound role in the shaping of orthopedic surgery, and to afford men with foresight, ability and dedication to grow with them. These were institutions and men to be reckoned with, and they will be long remembered.

Dr. Garceau came to the Indiana University Medical School in 1928, was named Chief Orthopaedist to the Riley Hospital in 1934, and became chairman of an autonomous department of Orthopaedic Surgery in the medical school in 1947. In his words, he inherited a "Rickety Old Stool," of which he was to make what he could. I believe that the pre-eminence to which the chair and its occupant have risen, speaks well enough for his handiwork.

Might + Right

There was a time in medicine when ascending in any of its fields was determined by the force a man could muster, political or otherwise. Yet among gentlemen, force must yield to reason and persuasion and these in turn to the effective action necessary to back them up. Chance and the prepared mind don't always find each other, and for all its virtues, serendipity is not reliable.

The student of orthopedics was, and still is, prepared to deal with the problems of both the defects and deformities of the musculo-skeletal system and of fractures gone awry. It follows naturally that he should assume a primary role in the treatment of the fresh injury, so that sooner or later, in nearly all institutions, musculo-skeletal injury became the responsibility of the orthopedic surgeon. At the Indiana University Medical Center that time came early. Yet throughout the development of this Orthopaedic Department, treatment of the crippled child remained the forefront of concern, not alone because of the need for such service, but because the principles of orthopedics could nowhere else be so well illustrated and taught. Orthopedic surgery at Indiana University advanced steadily in competence and stature and in the respect of the profession and public alike.

World War II, while it temporarily depleted the resident ranks, was destined to kindle an interest in orthopedics in many a physician, thrust unprepared into a welter of musculo-skeletal trauma. The large number of enthusiastic applicants who appeared after the war taxed the facilities available to train them. The returnees whose training here had been interrupted were accepted first, and then as many others as could be accommodated. With an eye to the future needs of

* The First Garceau Memorial Orthopaedic Lecture given at Indiana University Medical School, May 11, 1966.

†Professor and chairman, Department of Orthopaedic Surgery, Texas Southwestern Medical School, Dallas. Dr. Gregory was graduated from the I. U. School of Medicine in 1944.

others, this program accepted one of orthopedic's new responsibilities — to provide training in children's orthopedics for career Navy surgeons who could not get such training in regular Navy medical centers.

The heterogeneous background of this post-war group of residents, was to focus on a unique characteristic of the Riley program. Some were appalled, but most were to applaud, the idea that a "resident's" opinion should be heard — that residents were not simply to emulate, mimic or regurgitate — but to *Think!* The only stipulation was a simple one. The resident's conclusion might be forgivably wrong — but his facts must be unforgivably correct!

The focal point of any orthopedic community is logically to be found in its leading educational institution. Yet sustaining a reputation requires not only leadership at home, but participation in national organizations, and in basic professional policy-making as well. Moreover, the discovery, encouragement and support of capable young men is essential to secure the future. In keeping with its rising position in the orthopedic world, the Riley Orthopaedic Center has been involved in all of these activities, and the entire professional and public community, with all of its views and interests well served. But success, however it be measured, is ephemeral; perhaps even chimeric. Competition demands that it be recognized, and acknowledgement demands that it be sustained. How shall this be done? Perhaps to anticipate what lies ahead will provide a key.

Revolutionary Revisions

Toffler has put forward the notion, that this nation is likely to encounter what he has termed, "Future Shock." This he describes as the dizzying disorientation brought about by the premature arrival of the future. Computerized automation is a tangible expression of it. The problems of last year, which by conventional methods might have been solved next year, are often in fact being solved this year. Yet mankind is not always certain about what to do with the answers already at hand, and medicine will not be spared this impact. The millenium does not lie in the answers themselves, but in the use to which the answers are put! We may not always appreciate that fundamental, for it must be sought among the trappings which accompany it. Teaching machines may become commonplace tomorrow; medical school curricula are headed for profound revision; Bio - Information Centers will sort and reproduce great masses of information, and relay it widely via television or similar transmission medium. There will be a broadening spectrum of interests in Orthopaedic Surgery, with a concomitant narrowing of primary interest by the individual orthopedic surgeon, and a subsequent greater depth of understanding.

Yet how can orthopedic surgery maintain a cohesion in this welter of diversified interests and achieve continuity of effort and purpose? It must, perforce, be sustained within such educational centers as this one. An educational system on paper, which envisions a goal of broad yet coherent activities, is only a concept. Practical or impractical, such schemes are always pregnant with greater expectations than they can deliver. A didactic program may implement such a concept; a beginning, often impersonal, that seldom sustains the thrust of enthusiasm with which it was begun. Implementation by a "conventional committee" is usually an expedient compromise, and may also fail. Recall, if you will, the observation that a camel appears to have been designed by a committee. If these measures are likely to fail, what's to be done?

A Man of Stature

The greatest single force, which has produced and sustained the best in mankind, is the power of example. This is as true of a program in orthopedic surgery as in any other phase of the education of men. One act, in bad faith, can destroy all of the lip service which can be paid to an espoused, but violated principle! Example is the only way to sustain such intangibles as unpretentious humility: — respect for the views of others, and for a worthy foe: — resiliency with flexibility: — acceptance of a setback, without accepting defeat: — and a belief that life is worth living well. Example alone can kindle and nurture a sense of medical morality, and illustrate the incomparable value of integrity. These are the things which will determine what will be done with tomorrow's answers.

In so far as the chief of training program embodies these characteristics, he will have stature — and the stature of his program is usually but a reflection of his own. The heart of a training program is its chief. It has always been so, and it always will be.

The Indiana University Medical Center, and the students, interns and residents who have passed through its Orthopaedic Department have been fortunate indeed, that the career of George J. Garceau lead him here. He has given unstintingly, and pursued its interest unfailingly, for these many years. The "Heart" of this training program was indeed the "Heart" of this good man.

Such dedication and service is not bought without price. Every hour spent here was subtracted from time at some other place. Most often, we know, it was taken from home, from wife and family, who though they had less time with him, had not less of his devotion. Their particular interest in the training program is fully recognized, and acknowledged — and properly so.

It is an honor not often given a man to initiate a series of addresses honoring his "chief"; and less often can he address his remarks to the chief himself. Honored by my peers in being selected to do so — I become in fact, only the spokesman for all those, who having had all, or a part of their training here, are numbered among the "Riley Orthopaedic Alumni." In trying to find a suitable way to express

our feelings as your students, residents, colleagues and friends, a phrase I once heard from another resident says it best:

We consider you a success because: You have the confidence of children. The respect of your colleagues, and the love of your family.

Doctor and Mrs. Garceau, for a man and wife who had no sons, you have a great many boys. Tonight they all salute you! ◄

Gleaned from the British Medical Journal

JACK W. HICKMAN, M.D.
Indianapolis

Unpredictable Quinidine Toxicity

Six episodes of syncope, one of which was fatal, attributed to quinidine are reported by Davies, Leak and Oram.[1] Two particularly frightening aspects of this report are that the syncopal episodes were not dose-related and there were no pathognomonic EKG changes that warned that such syncopal episodes might be approaching. All six cases were brought about by toxic cardiac arrhythmias. The absence of toxic signs from the commonly-used "test dose" was of no reassurance that a patient would not later develop syncope. The authors have been so impressed by quinidine toxicity they feel that, if direct-current shock is available, quinidine should not be considered as therapy for paroxysmal arrhythmias.

Aspirin the Equal of Cortisone?

The results of a ten-year study of the natural history of rheumatic fever and rheumatic heart disease are presented in a well-written article.[2] This study was undertaken as a joint study by institutions in England, Canada and the United States. One of the most important aspects of the study was a comparison of the relative merits of ACTH, cortisone and aspirin in the treatment of rheumatic fever. The study showed no difference in the three treatments as far as an effect on prognosis. The greatest prognostic factor was the cardiac status at the time that treatment was begun. In fact, 94% of patients who had no evidence of carditis at the time any mode of therapy was instituted had no residual heart disease at the end of 10 years. For those patients who had carditis and/or congestive heart failure, only 32% had no disease at the end of 10 years. The disease was significantly more serious in females than in males. These findings, in addition to others, make this report a valuable one and one that deserves the attention of physicians dealing with rheumatic fever and its consequences.

Coronary Heart Disease Serious in Britain

An article by Thould[3] adds further observations to our knowledge of coronary heart disease. He analyzed all the admissions of patients over 65 years of age to a London hospital over a three-year-period. His results showed that only three per cent of these admissions were because of coronary heart disease. These patients had quite severe disease, however, since there was a 79% mortality rate. This certainly is evidence against the statement that has been made by others to the effect that this disease is more severe in the young because they have not had years to develop collateral circulation as older patients have. The author also notes that females tolerated the disease better than males, and that a very high percentage (50%) of coronary occlusions were "silent" or "painless" in the group studied.

Clubbed Fingers, the Vagus Nerve and Colitis

A brief report by Young[4] tends to place the frequency of clubbed digits and ulcerative colitis in its proper perspective. He reports on 77 cases of ulcerative colitis who were seen during a 10-year-period of time. Only seven of these patients were found to have clubbed fingers. This group was composed of patients whose disease involved either the entire large bowel or the part innervated by the vagus nerve. In a group of 79 patients whose disease did not involve the bowel with vagus innervation, no patients were found with clubbing. This study lends further support to the hypothesis that the vagus nerve plays some role in the pathogenesis of this baffling occurrence.

BIBLIOGRAPHY

1. Davies, P., Leak, D., Oram, S.: Quinidine-induced Syncope, *Brit. Med. J.* 5460:517-520.
2. Joint Report by the Rheumatic Fever Working Party of the Medical Research Council of Great Britain and the Subcommittee of Principal Investigators of the American Council on Rheumatic Fever and Congenital Heart Disease, American Heart Association, *Brit. Med. J.* 5462: 607-615.
3. Thould, A. K.: Coronary Heart Disease in the Aged, *Brit. Med. J.* 5470:1089-1093.
4. Young, J. R.: Ulcerative Colitis and Finger-Clubbing, *Brit. Med. J.* 5482:278-279. ◄

Most of my patients with high blood pressure are as old as I am. A lot of them are living on pensions. They're grateful when I can keep prescription costs down.
Regroton®
chlorthalidone 50 mg. reserpine 0.25 mg.
1 tablet daily brings pressure down
Advantage: Both components of Regroton are long-acting.
Average dosage: One tablet daily with breakfast.
Contraindications: History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases.
Warning: Discontinue 2 weeks before general anesthesia, 1 week before electroshock therapy, and if depression or peptic ulcer occurs. With administration of enteric-coated potassium supplements, the possibility of small bowel lesions should be kept in mind.
Precautions: Reduce dosage of concomitant antihypertensive agents by one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take particular care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use with caution in patients with ulcerative colitis, gallstones, or bronchial asthma.
Side effects: Nausea, vomiting, diarrhea, muscle cramps, headaches and dizziness. Potential side effects include angina pectoris, anxiety, depression, drowsiness, hyperglycemia, hyperuricemia, lassitude, leukopenia, nasal stuffiness, nightmare, purpura, urticaria, and weakness.
For full details, see the complete prescribing information.
Availability: Bottles of 100 and 1000 tablets.
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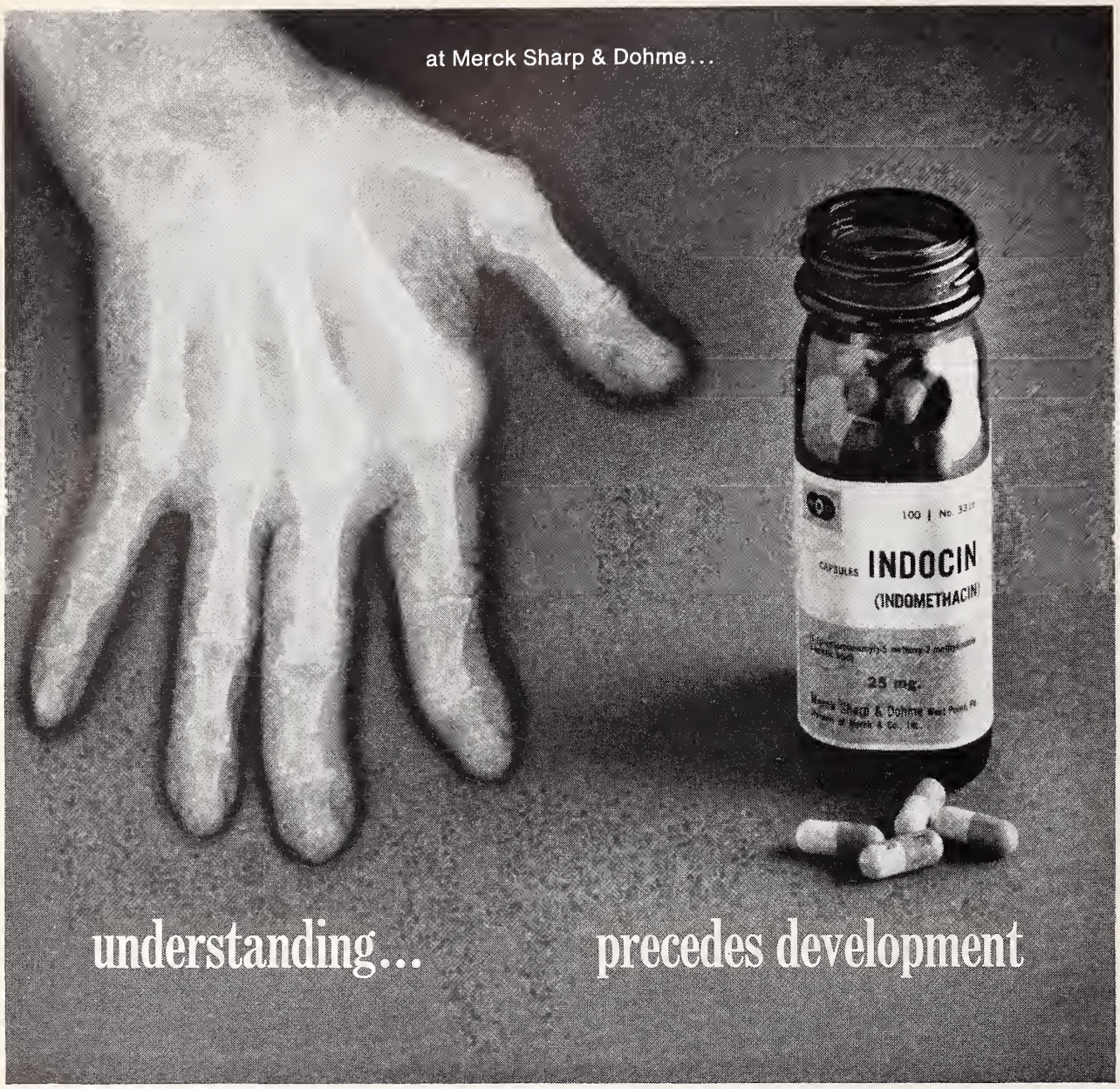

The synthesis of cortisone was accomplished by Merck Sharp & Dohme in 1948—the famous "Compound E" used by Dr. Philip Hench in his historic experiment at the Mayo Clinic.

But proud as we are of our role in the development of cortisone and subsequent corticosteroids, we have continued to seek a greater understanding of arthritic disorders and new drugs for their treatment.

One such drug—INDOCIN® (indomethacin), a nonsteroid, anti-inflammatory agent fundamentally different in structure and activity from other drugs in use—was recently made available for the treatment of arthritic conditions. It opens new possibilities for the long-term management of arthritis and inflammatory disease.

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INDOCIN®

INDOMETHACIN

Indications: Chronic and acute rheumatoid arthritis, rheumatoid (ankylosing) spondylitis, degenerative joint disease (osteoarthritis) of the hip, and gout.
Contraindications: Active peptic ulcer, gastritis, regional enteritis, or ulcerative colitis. Safety in pregnancy has not been established. Not recommended for pediatric age groups.
Warning: Patients who experience dizziness, lightheadedness, or feelings of detachment on INDOCIN should be cautioned against operating motor vehicles, machinery, climbing ladders, etc. Use cautiously in patients with psychiatric disturbances, epilepsy, or parkinsonism.
Precautions and Adverse Reactions: Most commonly, headache, dizziness, lightheadedness, G.I. disturbances. The C.N.S. effects are often transient and frequently disappear with continued treatment or reduced dosage. The severity of these effects may occasionally require cessation of therapy. G.I. effects may be minimized by giving the drug with food or with antacids or immediately after meals. Ulceration of the stomach, duodenum, or small intestine has been reported and, in a few instances, severe bleeding with perforation and death. Gastrointestinal bleeding with no obvious ulcer formation has also been noted; INDOCIN should be discontinued if G.I. bleeding occurs. As a result of G.I. bleeding, some patients may manifest anemia, and for this reason periodic hemoglobin determinations are recommended. Rare reports of effects not definitely known to be attributable to INDOCIN include bleeding from the sigmoid colon (either from a diverticulum or without a known previous pathologic condition), perforation of preexisting sigmoid lesions (diverticulum, carcinoma), and hematuria. In other rare cases, a diagnosis of gastritis has been made while the drug was being given. One patient developed ulcerative colitis, and another, regional ileitis, while receiving INDOCIN; when the drug was given to patients with preexisting ulcerative colitis, there was an increase in abdominal pain. Infrequently observed side effects may include drowsiness, tinnitus, mental confusion, depression and other psychic disturbances, blurred vision, stomatitis, pruritus, edema, and hypersensitivity reactions. Slight BUN elevation, usually transient, has been seen in some patients, although the preponderance of evidence indicates that INDOCIN does not adversely affect renal function, even in patients with preexisting renal disease. Nevertheless, renal function should be checked periodically in patients on long-term therapy. Leukopenia has been seen in a few patients. Transient elevations in alkaline phosphatase, cephalin-cholesterol flocculation, and thymol turbidity tests have been observed in some patients and, rarely, elevations of SGOT values; the relationship of these changes to the drug, if any, has not been established. As with any new drug, patients should be followed carefully to detect unusual manifestations of drug sensitivity. Before prescribing or administering, read product circular with package or available on request.

Preparation of Medicare Claim Forms

(One of a series prepared by Indiana Blue Cross-Blue Shield)

At the time of writing, Blue Shield has had one month's experience handling Medicare claims. As anticipated, our volume during this period has been light, averaging 340 claims a week during July. Our problems in processing the claims submitted have been no more than would be expected in connection with any new program, but we do have a few procedural suggestions that would simplify handling and speed up payment of claims with a minimum of correspondence, and a minimum of additional paper work.

Most of our problems during July have been in the area of differentiating between "Paid Receipt" and "Assignment" claims.

The law governing the administration of Medicare requires that if the physician and patient elect not to accept assignment, the patient should fill out and sign Part I of the SSA Medicare claim form, and the physician should furnish the patient an itemized bill or bills marked "Paid" to be submitted to Blue Shield by the patient, attached to the claim form.

Conversely, if the physician and the patient elect to accept assignment, the patient should fill out and sign Part I of the SSA Medicare claim form, and the physician should fill out and sign Section II of the form. The physician submits this type of claim to Blue Shield, and the Blue Shield check in turn is mailed direct to the physician.

The second problem area is that of identification numbers. The health insurance number copied from the patient's SSA Health Insurance Card needs to be entered in the "Claim Number" space at the top of the Medicare claim form. This number must be complete — and include the suffix. If the patient has the Blue Shield Medicare Supplement program, the Blue Cross-Blue Shield Identification Number needs to be entered in the blank space just below the health insurance number. Several other problems include:

Anesthesia claims — Since these claims are paid on the basis of "length of time", this entry must be made either on the claim form used, or on the receipted bill, depending upon the method of payment selected.

The physician's diagnosis must be entered by the patient in Part I of the claim form for "Paid Receipt" claims. This item need not be completed by the patient in the case of "Assignment" claims, but the physician must enter the diagnosis in Part II. If the diagnosis is not known, then the provisional diagnosis or complaints and symptoms must be given instead.

If the above suggestions are followed, problems will be eliminated for physicians, patients, and Blue Shield, and payments can be made swiftly and efficiently. ◄

W. C. Huddlestone
Communications Division

117th Annual Convention

INDIANA STATE MEDICAL ASSOCIATION

October 10-13

French Lick, Indiana

DON'T DELAY IN MAKING RESERVATIONS . . .

Art, Hobby Show Planned For ISMA French Lick Meeting

Space will be provided at the 1966 annual meeting of the Indiana State Medical Association, Oct. 10-13 at French Lick for a Physicians Art and Hobby Show.

Members of ISMA interested in exhibiting pieces and requiring any information regarding this can contact any one of the following:

Dr. Charles P. Schneider
2211 W. Franklin St.
Evansville

Dr. Ray H. Burnikel
517 Sycamore St.
Evansville

Dr. Truman E. Caylor
303 S. Main St.
Bluffton

Dr. Frank H. Coble
51 S. Eighth Street
Richmond

Dr. Lall G. Montgomery
Ball Memorial Hospital
Muncie

ISMA Headquarters
3935 N. Meridian
Indianapolis

It will be the responsibility of each physician to see that his work gets to the exhibition at the French Lick-Sheraton Hotel. Final arrangements will be taken care of by Drs. Schneider and Burnikel, co-chairmen.

The ISMA will provide suitable display facilities, but each physician is responsible for transportation costs and any other such expense involved in entering his exhibit.

We solicit your exhibit to make this the largest and best ever this year.

Application for Space in Art and Hobby Show Exhibit

Mail to:

Dr. Charles P. Schneider
2211 W. Franklin St.
Evansville

Name_____

Address_____

City_____

Type and number of pieces to be displayed: Photography_____

Sculpture_____

Crafts_____

Painting_____

Other_____

Estimated amount of space required—lineal or square feet_____

Other information_____

UP TO 10–12 HOURS' CLEAR BREATHING ON ONE TABLET

Dimetapp® Extentabs®

(Dimetane® [brompheniramine maleate], 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.)

In sinusitis, colds, or U.R.I., Dimetapp lets congested patients breathe easy again. Each Extentab brings welcome relief all day or all night, usually without drowsiness or overstimulation. Its key to success? The Dimetapp formula—Dimetane (brompheniramine maleate), a potent antihistamine reported in one study to have elicited side effects as few as the placebo,* teamed with decongestants phenylephrine and phenylpropanolamine—in a dependable 10- to 12-hour form.

*Schiller, I. W., and Lowell, F. C.: New England J. Med. 261:478, 1959.

Contraindications: Patients hypersensitive to antihistamines. Not recommended for use during pregnancy.

Precautions: Until the patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.

Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability, or excitement may be encountered.

Dosage: 1 Extentab morning and evening, or as needed.

Supplied: Bottles of 100 and 500.

Also available: Dimetapp® Elixir for conventional *t.i.d.* or *q.i.d.* dosage. See package insert for further details.

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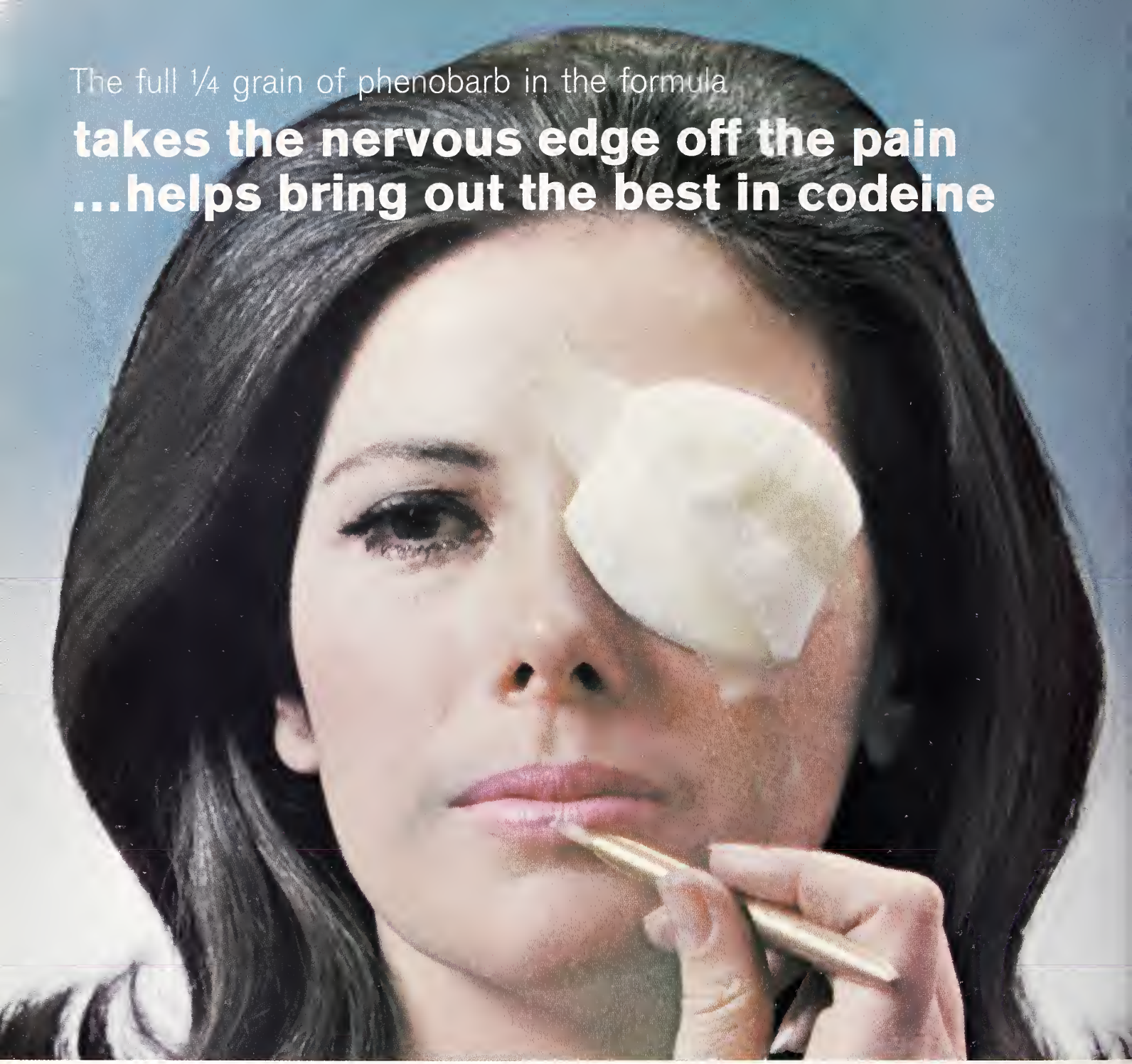

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Each capsule contains:

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(Warning: may be habit forming)
Aspirin (2½ gr.) .....162.0 mg.
Phenacetin (3 gr.) .....194.0 mg.
Hyoscyamine sulfate .....0.031 mg.
Codeine phosphate.....¼ gr. (No. 2), ½ gr. (No. 3), 1 gr. (No. 4)
(Warning: may be habit forming)

Contraindications: Hypersensitivity to any ingredient.

Precautions: As with all phenacetin-containing products, avoid excessive or prolonged use.

Side Effects: Side effects are uncommon—nausea, constipation, and drowsiness have been reported.

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Annual Meeting Dates of Professional Medical and Allied Organizations

AMERICAN MEDICAL ASSOCIATION CLINICAL MEETING
Date November 27-30, 1966
Place Las Vegas, Nevada

INDIANA HOSPITAL ASSOCIATION
Date Nov. 2-4, 1966
Place Marott Hotel, Indianapolis

NORTHERN INDIANA PSYCHIATRIC SOCIETY
Date Fourth Wednesday of every month, September through June
Place For location and program, inquire Beatty Memorial Hospital, Westville

INDIANA NEUROPSYCHIATRIC ASSOCIATION
Date Second Wednesday of the month, October through May, excluding December
Place The Athenaeum, Indianapolis

BONE AND JOINT CLUB
Date October 19, 1966
Place The Athenaeum, Indianapolis

INDIANA ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY
Date May 4-6, 1967
Place Stouffer Inn, Indianapolis

INDIANA PHARMACEUTICAL ASSOCIATION
Date July 18-20, 1967
Place French Lick Sheraton Hotel, French Lick

INDIANA ACADEMY OF GENERAL PRACTICE
Date May 3-4, 1967
Place Murat Temple, Indianapolis

INDIANA STATE MEDICAL ASSOCIATION CONVENTION
Date October 10-13, 1966.
Place French Lick, Indiana

INDIANA PUBLIC HEALTH ASSOCIATION
Date April 26-27, 1967
Place Indianapolis

INDIANA OBSTETRICAL AND GYNECOLOGICAL SOCIETY
Date November 2, 1966
Place Howard Johnson's (downtown), Indianapolis

INDIANA ROENTGEN SOCIETY
Date May 7, 1967
Place Indianapolis

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About Our Cover

Would you believe — the 117th annual ISMA convention has everything?

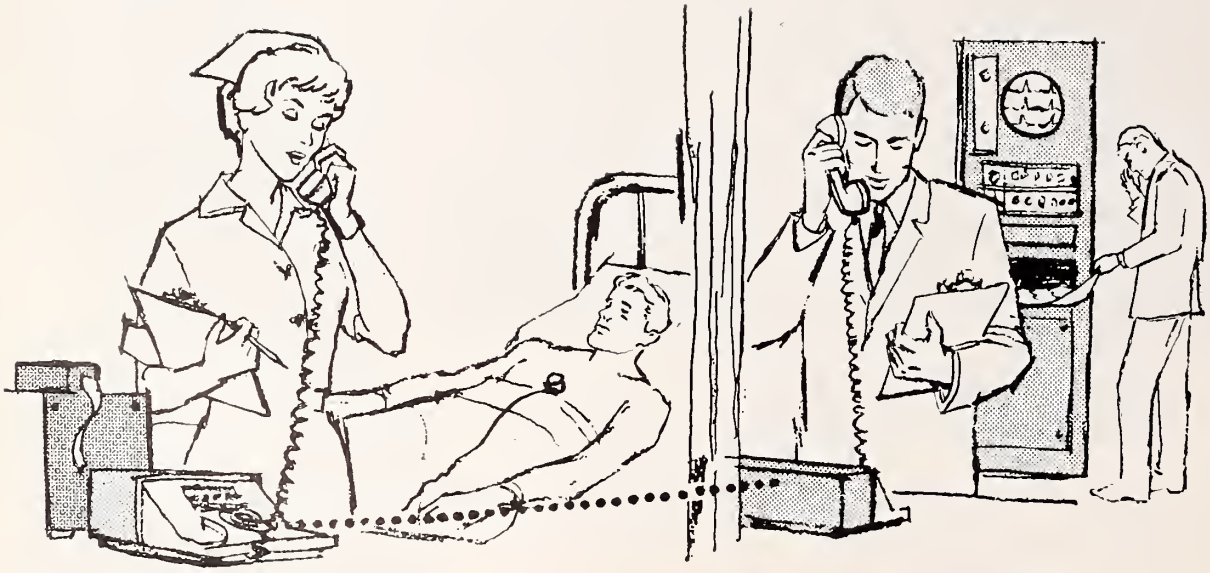
If not everything, then it comes mighty close to having something for everyone.

This issue of *The Journal* brings you all of the events which make up your annual convention. With it you can plan the programs you wish to attend and also get a preview of the scientific and technical exhibits.

Back this year after a brief absence will be the trap and skeet shoot and the golf tournament. Everything has been planned for your enjoyment, relaxation and entertainment.

In addition, you can learn what is new in the rapidly developing field of medicine. Fireside conferences; general scientific and section meetings; elections of section officers; past president's luncheon; women physicians' dinner meeting; a special supper, smoker and stag party; reception and luncheon for members of the Fifty-Year Club; the President's reception and annual dinner — all planned so that you can learn, be entertained and renew old acquaintances at the 1966 convention.

Don't miss it!—J.F.S.



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- Clinicians throughout the world consider meprobamate a therapeutic standard in the management of anxiety and tension.
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(meprobamate)

Indications: Meprobamate is effective in relief of anxiety and tension states. Also as adjunctive therapy when anxiety may be a causative or otherwise disturbing factor. Although not a hypnotic, meprobamate fosters normal sleep through both its anti-anxiety and muscle-relaxant properties.

Contraindications: Previous allergic or idiosyncratic reactions to meprobamate or meprobamate-containing drugs.

Precautions: Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Usual adult dosage: One or two 400 mg. tablets three times daily. Doses above 2400 mg. daily are not recommended.

Supplied: 'Miltown' (meprobamate) is available in two strengths: 400 mg. scored tablets and 200 mg. coated tablets. 'Meprotabs' (meprobamate) is available as 400 mg. white, coated, unmarked tablets. *Before prescribing, consult package circular.*

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Cranbury, N.J.

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Norinyl® tablets

(norethindrone 2 mg. c̄ mestranol 0.1 mg.)

for multiple contraceptive action that has produced a record of unexcelled effectiveness

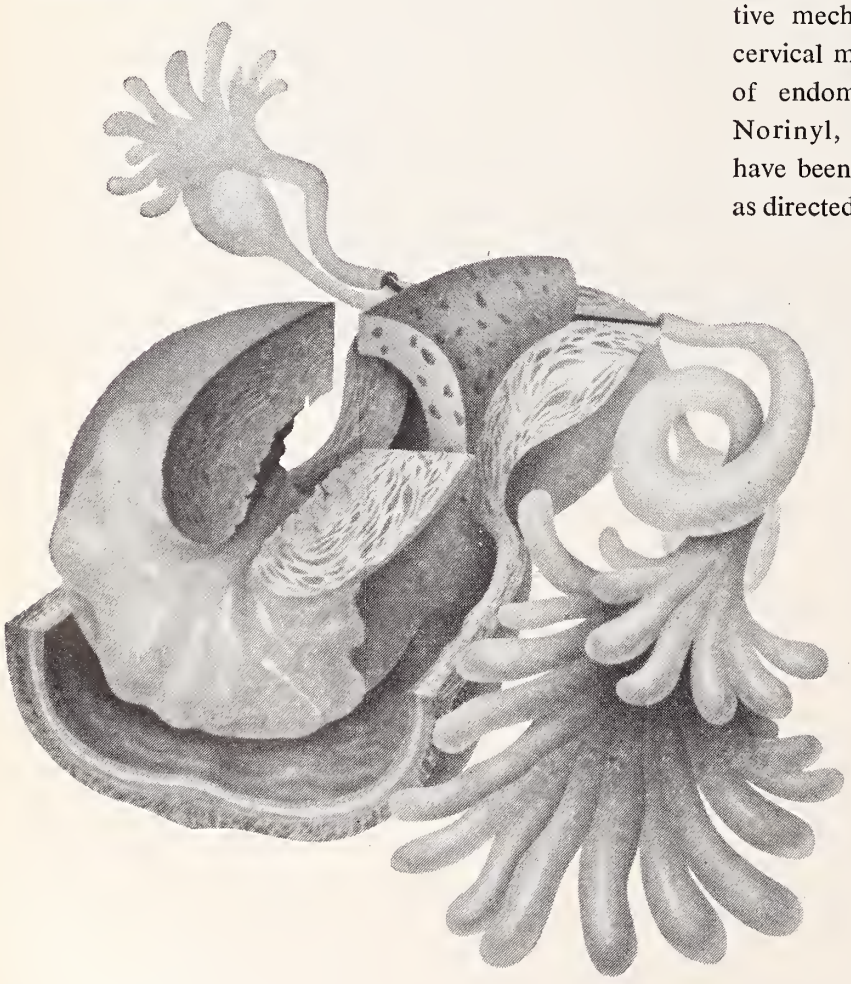
inhibition of ovulation by means of 2 time-proved hormonal agents

production of a cervical mucus hostile to sperm motility and vitality

creation of an endometrium unreceptive to egg implantation

no unplanned pregnancies

Norinyl provides multiple action for maximum assurance of success. It does not depend on ovulation inhibition alone for contraceptive effectiveness. The mechanism of action of combined hormonal therapy results in ovulation inhibition reinforced by other protective mechanisms, including a hostile cervical mucus[1-13] and an acceleration of endometrial changes.[1-3,7-16] With Norinyl, no unplanned pregnancies have been reported to date when used as directed.



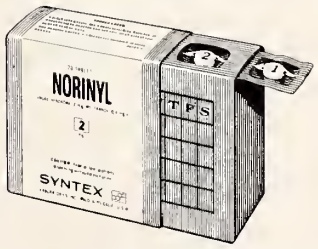
plus important supportive benefits that help her through those critical early months of oral contraception

low incidence of side effects

Low incidence of BTB and spotting, nausea and amenorrhea tends to minimize side effect problems and increases patient cooperation.

no confusion about dosage

An unbreakable "confusionproof" package makes it easy to adhere to prescribed dosage schedule: individually sealed tablets numbered from 1 through 20 *plus* monthly calendar record enables patient to double-check dosage intake by day and corresponding tablet number.



Contraindications: Thrombophlebitis or pulmonary embolism (current or past). Existing evidence does not support a causal relationship between use of Norinyl and development of thromboembolism. While a study which was conducted does not resolve definitively the possible etiologic relationship between progestational agents and intravascular clotting, it tends to confirm the findings of the Ad Hoc Advisory Committee appointed by the Food and Drug Administration to review this possibility. Cardiac, renal or hepatic dysfunction. Carcinoma of the breast or genital tract. Patients with a history of psychic depression should be carefully studied and the drug discontinued if depression recurs to marked degree. Patients with a history of cerebral vascular accident.

Warning: Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn.

Precautions: By May 1963, experience with norethindrone 2 mg.—mestranol 0.1 mg. had extended over 24 months. Through miscalculation, omission or error in taking the recommended dosage of Norinyl, pregnancy may result. If regular menses fail to appear and treatment schedule has not been adhered to, or if patient misses two menstrual periods, possibility of pregnancy should be resolved before resuming Norinyl. If pregnancy is established, Norinyl should be discontinued during period of gestation since virilization of the female fetus has been reported with oral use of progestational agents or estrogen. When lactation is desired, withhold Norinyl until nursing needs are established. Existing uterine fibroids may increase in size. In metabolic or endocrine disorders, careful clinical preevaluation is indicated. A few patients without evidence of hyperthyroidism had elevated serum protein-bound iodine levels, which in the light of present knowledge, does not necessarily imply hyperthyroidism. Protein-bound iodine increased following estrogen administration. Bromsulphalein retention has occurred in up to 25% of patients without evidence of hepatic dysfunction. Studies from 24-hour urine collections have shown an increase in aldosterone and 17-ketosteroids and decrease in 17-hydroxycorticoid levels. Thus, Norinyl should be discontinued prior to and during thyroid, liver or adrenal function tests. Because progestational agents may cause fluid retention, conditions such as epilepsy, migraine and asthma require careful observation. Thus far no deleterious effect on pituitary, ovarian or adrenal function has been noted; however, long-range possible effect on these and other organs must await more prolonged observation. Norinyl should be used with caution in patients with bone, renal or any disease involving calcium or phosphorus metabolism.

Side Effects: Intermenstrual bleeding; amenorrhea; symptoms resembling early pregnancy, such as nausea, breast engorgement or enlargement, chloasma and minor degree of fluid retention (if these should occur and patient has not strictly adhered to medication plan, she should be tested for pregnancy); weight gain; subjective complaints such as headache, dizziness, nervousness, irritability; in a few patients libido was increased. In a total of 3,090 patients, 2.2% discontinued medication because of nausea.

NOTE: See sections on contraindications and precautions for possible side effects on other organ systems.

Dosage and Administration: One Norinyl tablet orally for 20 days, commencing on day 5 through and including day 24 of the menstrual cycle. (Day 1 is the first day of menstrual bleeding.)

Availability: Dispensers of 20 and 60 tablets; bottles of 100.

References: 1. Council on Drugs. JAMA 187:664 (Feb. 29) 1964. 2. Brvans, F. E.: Canad Med Ass J 92:287 (Feb. 6) 1965. 3. Goldzieher, J. W.: Med Clin N Amer 48:529 (Mar.) 1964. 4. Cohen, M. R.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965. 5. Hammond, D. O.: Ibid. 6. Rice-Wray, E., Goldzieher, J. W., and Aranda-Rosell, A.: Fertil Steril 14:402 (Jul.-Aug.) 1963. 7. Goldzieher, J. W., Moses, L. E., and Ellis, L. T.: JAMA 180:359 (May 5) 1962. 8. Kempers, R. D.: GP 29:88 (Jan.) 1964. 9. Tyler, E. T.: JAMA 187:562 (Feb. 22) 1964. 10. Rudel, H. W., Martinez-Manautou, J., and Maqueo-Topete, M.: Fertil Steril 16:158 (Mar.-Apr.) 1965. 11. Flowers, C. E., Jr.: N Carolina Med J 25:139 (Apr.) 1964. 12. Goldzieher, J. W.: Appl Ther 6:503 (June) 1964. 13. The Control of Fertility. Report adopted by the Committee on Human Reproduction of the American Medical Association. JAMA 194:462 (Oct. 25) 1965. 14. Flowers, C. E., Jr.: JAMA 188:1115 (June 29) 1964. 15. Merritt, R. I.: Appl Ther 6:427 (May) 1964. 16. Newland, D. O.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965.

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LABORATORIES INC., PALO ALTO, CALIF.

Norinyl® tablets
(norethindrone 2 mg. c̄ mestranol 0.1 mg.)

for multiple contraceptive action

Medicine At Law

DECISIONS AND OPINIONS

Highlights of recent court actions pertaining to health and medicine from *The Citation* prepared by the Law Division of AMA.

Vaccination as Condition of School Attendance Not Violation of Freedom of Religion — A trial court did not err in declaring that a child who was not attending an accredited school, because of his parents' refusal, on religious grounds, to have him vaccinated, was neglected and in appointing a guardian for him for the purpose of consenting to the vaccination, the Arkansas Supreme Court ruled.

The child attends a school operated by the religious sect to which his parents belong. Vaccination is contrary to the sect's religious beliefs. A Board of Health Regulation requiring a child to be vaccinated as a condition for school attendance is a valid and reasonable exercise of the state's police power and does not violate the right to freedom of religion. Since the regulation has the force and effect of law, the child's school attendance, in violation of the regulation was sufficient to sustain the finding that he was neglected and to justify the appointment of the guardian.

Mannis v. State of Arkansas ex rel. DeWitt School District No. 1, 398 S.W. 2d 206 (Ark., Jan. 10, 1966; rehearing denied, Feb. 14, 1966).

Public Policy Not Violated by Advertisements in Physician's Book — A physician, the author of a book on baby and child care, was not entitled to an order declaring that the provision of his agreement with his publisher permitting the insertion of advertisements for baby and child care products in the book was null and void, and enjoining it against the future inclusion of advertisements in the book, a New York trial court ruled.

It is not the state's public policy that a physician's endorsement of commercial products so endangers the public health and welfare as to subject him to the loss of his license. Nor are contracts with a physician for the endorsement of commercial products void and unenforceable. The opinion of the American Medical Association, first expressed in 1964, that a physician should not endorse any product, because to do so adversely reflected on the profession's honor and dignity, merited careful consideration. However, it did not establish that such action also adversely affected the public health, safety and welfare, and it has not been shown that such endorsements have injured the public. It is obvious, as evidenced by the fact that the American Dental Association has permitted the commercial exploitation of certain of its findings by a dentifrice manufacturer, that differences of opinion exist among members of the healing arts as to dangers arising from commercial endorsements. The physician may have subjected himself to professional censure by authorizing the advertising, but that does not establish that some public policy had been violated, the court said.

Spock v. Pocket Books, Inc., 266 N.Y.S. 2d 77 (N.Y., Dec. 15, 1965).

Res Ipsa Loquitur Applicable to Suit for Injuries Sustained Under Anesthesia — A patient was entitled to have her suit for damages against an anesthesiologist and a hospital, for nerve injuries allegedly sustained while she was under anesthesia for an operation, submitted to the jury on the theory of *res ipsa loquitur*, a New York intermediate appellate court ruled.

The patient allegedly sustained injuries in an area unrelated to that of the operation as the result of trauma caused by an external force. The patient's medical expert began to treat her shortly after she allegedly sustained her injuries and continued to do so for several years until her condition was corrected by an operation. The information thus gained, together with the patient's history and her testimony, was sufficient to support the expert's opinion that her injuries were caused by negligence while she was under anesthesia.

The patient was entitled to have the case against the hospital go to the jury because it was liable for any negligence on the part of its employees. The evidence showed that the hospital employees who participated in the operation were under the concurrent control of the hospital and the anesthesiologist.

Matlick v. Long Island Jewish Hospital, 267 N.Y.S. 2d, 631 (N.Y., Feb. 14, 1966).

Government Liable for Injuries Caused by Hospital Staph Infection — A patient was entitled to recover damages in a suit against the government,

under the Federal Tort Claims Act, for injuries sustained as the result of a staphylococcus infection contracted while she was being cared for in the premature nursery of a Navy hospital, a federal trial court ruled.

Following her premature birth, the patient was kept in an isolette in the premature nursery. About two weeks after birth, it was noted that both of the patient's hip joints were swollen and that she had a fever. Both hips were incised and drained. Laboratory tests established that the material drained from her hips contained staphylococcus aureus coagulase positive.

Nose and throat cultures were then taken from all of the personnel working in the nursery and one WAVE had a positive nose culture containing staphylococcus aureus. The WAVE had been working in the nursery for a month. Her last assignment, at another Navy hospital, had been in the pediatric clinic where there were both sick and well children. She had been assigned to the nursery without being given a physical examination of any kind. An antibiogram of cultures from the patient and the WAVE disclosed that, as to the seven antibiotics against which they were tested, the patient's culture was sensitive to two and the WAVE's to five, two of which were the same two to which the patient's was sensitive.

The patient's right hip was permanently dislocated and there has been a destructive process in the joint of her left hip which will probably cause pain in later life. When the patient is fully grown, her left leg will probably be two inches shorter than her right. She now walks with a "sway" and a limp, and has to wear an orthopedic brace which causes considerable pain.

There was testimony that the WAVE handled the patient under such circumstances that she could have transmitted the staph infection to her. There was expert opinion testimony that the two strains of staph were the same and that the WAVE had transmitted the infection to the patient. This evidence established that there was a causal connection between the government's acts or omissions and the patient's injuries, the court said. The patient cannot be denied recovery because the hospital did not use the phage test to determine exactly which strain of staph was present in the two cultures.

Two medical experts testified that it would be contrary to accepted community standards to take a person who has been working in another department or ward of the hospital in which infections or contagious diseases were treated and put her to work in the nursery immediately, and that this was particularly true as to nurseries where premature babies were being cared for. The fact that the WAVE came from the pediatrics clinic of a different hospital made no difference as far as the application of this standard was concerned, the court said. A medical expert for the government testified that the local hospital with which he was connected did no culture testing of the personnel assigned to its nursery. He stated that, if there was an asymptomatic carrier employed in the nursery, the hospital preferred not to know about it. Conformity with the standard of care followed by other hospitals in the community is not a defense where that standard constitutes negligence in that it fails to meet the test of reasonable care and diligence. Permitting the WAVE, who had not been given a proper physical examination before going to work in the nursery, to come in critical contact with the patient, who was particularly susceptible to infection, constituted negligence, the court said.

Kapuschinsky v. *U.S.*, 248 F. Supp., 732 (D.C., S.C., Jan. 3, 1966).

Blood Transfusions Ordered for Patient who Refused, Because of Religious Beliefs, to Sign Consent — An order authorizing a hospital to administer such blood transfusions as her attending physicians might deem necessary to save the life of a post-Caesarean patient who had bled extensively but who, because of her religious beliefs as a Jehovah's Witness, refused to give her written consent to transfusions was granted, at her husband's request, by a New York trial court. The patient did not object to receiving the treatment involved, but she refused to direct that it be given. The hospital took the position that, since it had obtained from the patient a signed release of liability for any consequences of its failure to give blood transfusions, it had

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satisfied its obligation to the patient and would not give her blood transfusions even if they were necessary to save her life. This case illustrated the extent to which society and the individual have become enmeshed and paralyzed by an ultralegalistic maze, the court said; but, since the patient obviously wanted to live, it felt that it must authorize the transfusions.

Powell v. Columbian Presbyterian Medical Center, 267 N.Y.S. 2d, 450 (N.Y., Dec. 24, 1965).

$60,000 General Damages Awarded for Loss of Eye — In a suit against the government, under the Federal Tort Claims Act, a retired Marine who suffered almost total loss of vision in his right eye as the result of a Navy physician's negligence in examining his eye was awarded general damages of $60,000 by a federal trial court.

The injury to the eye occurred when the physician placed a tonometer on the marine's eyeball without first allowing it to cool sufficiently after removing it from the sterilizer. The government admitted liability.

The Marine recovered the amount of past doctor and drug bills and wages lost. He was awarded $3,500 for future medical expenses to cover, among other things, a recommended corneal transplant when circumstances made the operation possible.

Recent damage awards in other federal court cases for the loss of an eye have ranged from $23,000 to $100,000. The Marine's pain and suffering have been minimal, but he has been visually handicapped for a year. He may never regain the use of the eye, even though he submits to one or more corneal transplant operations. He is only 42 years old. Under all the circumstances, he was entitled to general damages of $60,000, the court said.

Owen v. U.S., 251 F. Supp. 38 (D.C., Cal., March 15, 1966).

Physician's License Suspended for Failure to Keep Narcotics Records — The Board of Regents' suspension of a physician's license for two months, because of his failure to keep the records required by federal and state law as to the narcotic drugs administered, dispensed, and professionally used by him, was upheld by a New York intermediate appellate court. Although the Committee on Grievances had recommended that the physician be only censured and reprimanded, the punishment imposed was proper because it was not disproportionate to the offense of which he was found guilty. This was particularly true in view of the fact that, when he had previously been found guilty of a similar charge, he had only been censured and reprimanded.

Rear v. Board of Regents of the University of the State of New York, 265 N.Y.S.2d 421 (N.Y., Dec. 23, 1965).

Physician's License Properly Revoked for Illegal Treatment of Drug Addict — The license of a physician was properly revoked on the ground that he had been guilty of unprofessional conduct in having prescribed Methedrine for drug addicts as treatment for their addiction, a California intermediate appellate court ruled.

When the physician was out of town, his office nurse was arrested under a warrant charging her with unlawfully prescribing drugs, and the office records of the patients that the physician was treating by prescribing Methedrine were seized by the officers. The officers did not have a search warrant. The physician contended that the seizure of the records was unlawful and that the revocation was invalid because it was based on evidence obtained from those records.

It would presume that the exclusionary rule as to illegally obtained evidence applied in an administrative proceeding which contemplated the deprivation of a property right such as a license to practice medicine, the court said.

Since the nurse's arrest was valid, the search incident thereto was valid. The search was valid even though the officers had ample time in which to obtain a search warrant. The fact that the records were seized from his nurse did not preclude their admission in evidence against the physician. He had left her in control of the office and instructed her to use the cards in writing prescriptions for Methedrine for patients, the offense for which she was arrested.

The cards themselves were not admitted in evidence. Even if it could be said that the search was unlawful, testimony naming certain patients, who were among those listed on the cards seized, and identifying them as addicts was properly admitted. It was not shown that this testimony was derived from information on the cards. The information could have been legally obtained from the records of pharmacists who filled prescriptions for the patients.

The physician testified that he pre-

Continued

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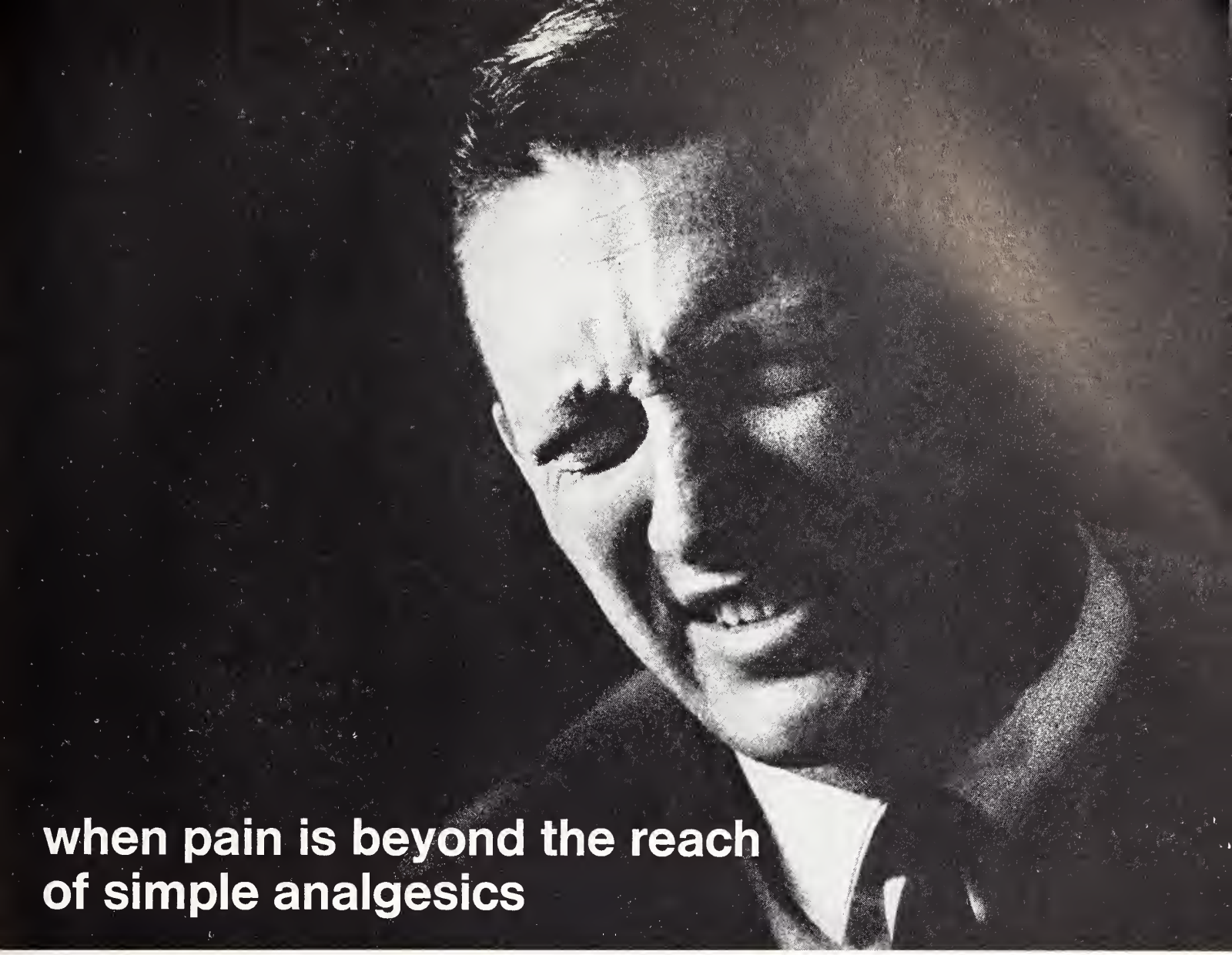

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1. Collective studies, Department of Medical Research, Winthrop Laboratories.

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scribed the Methedrine for his patients as a substitute for the narcotics to which they were or had been addicted. The patients were addicts while they were receiving the substitute drug and the prescribing of the substitute drug constituted treatment for their addiction. Whether the physician's method of treating the addicts was better than those prescribed by law was not a matter for its determination, the court said.

Elder v. Board of Medical Examiners, 50 Cal. Rptr. 304 (Cal., March 31, 1966).

Physicians and Hospital not Liable for Patient's Fall — A patient was not entitled to recover damages in a suit against three physicians and a hospital for injuries sustained in a fall in the hospital, a Texas intermediate appellate court ruled.

The physicians operated on the patient's right eye for a detached retina. One evening, when his daughter was the only person with him in his hospital room, he announced his intention to get up and go to the bathroom and ordered her from the room. When she returned to the room with her mother a few minutes later, they found the patient on the floor. His neck was broken and he subsequently lost the sight of his right eye. The patient contended that the physicians and the hospital were negligent in having failed to install bed rails on the bed and that this was the proximate cause of his fall.

The physicians testified that patients who are physically able to do so frequently crawl over bed rails and that the patient could have done so if there had been rails on the bed. The record did not show how the patient fell or what factors might have contributed to the fall. He could have rolled from the bed; stood up in bed and fallen; fallen while trying to get out of bed; gotten out of bed, walked, and then fallen; or fallen after going over the end of the bed where bed rails are ordinarily not installed.

There were no facts from which the jury could evaluate the fall and determine if bed rails would have prevented it. The jury could do no more than determine that the fall occurred and from that fact could do no more than speculate or conjecture as to its proximate cause. Proximate cause cannot be established by conjecture but must be proved.

Bowen v. East Texas Hospital Foundation, 400 S.W. 2d 843 (Tex., March 3, 1966; rehearing denied, March 24, 1966).

Manufacturer Not Liable to Patient Who Contracted Polio After Taking Oral Vaccine — In a suit for damages against a manufacturer of Sabin oral polio vaccine by a patient who contracted anterior poliomyelitis three weeks after taking the vaccine and is now permanently paralyzed from vertebra T-6 down, a verdict in favor of the manufacturer was returned by a federal trial court jury in Idaho. The case was submitted to the jury on only the theory of breach of implied warranty. The patient had also alleged breach of an express warranty, negligence in the vaccine's manufacture, and violation of the Montana food and drug laws, and had argued that the doctrines of absolute liability and res ipsa loquitur were applicable.

The patient took the vaccine after various reports of the surgeon general were issued in the fall of 1962 in which the belief was stated that there was a danger in the use of the vaccine. However, the trial court denied the patient's request that the jury be instructed that the manufacturer had negligently failed to warn the public of any inherent danger in the use of the vaccine.

Davis v. Wyeth Laboratories, Inc., Docket No. 3973 (D.C., Idaho, Jan. 28, 1966).

Hospital Property Rented to Staff Members for Offices Taxable — The portion of a building owned by a nonprofit hospital association which it leased to key physicians on its staff as office space was not exempt from real estate taxation, the Ohio Supreme Court ruled. The hospital did not rent the space to the physicians for the purpose of making a profit and the building in which it was located was connected with the hospital building. The staff members occupying the offices practiced their profession there and personally charged their patients for their services. There was no evidence of any charitable activity being carried on in the space involved. Since the space was being used commercially, it was not exempt from taxation.

White Cross Hospital Association v. Warren, 215 N.E. 2d 374 (Ohio, March 30, 1966). ◀

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BOOK REVIEWS

COMMUNICABLE AND INFECTIOUS DISEASES

Franklin H. Top, The C. V. Mosby Company, St. Louis, Mo., fifth edition, 1964; 133 figures and 15 color plates; 902 pages; $21.00.

This new fifth edition shows further refinement over the previous editions. The writings on rapidly changing chemotherapy, antibiotics, new viral infections and specific prevention of certain communicable diseases are up-to-date and well organized. Several new chapters have been added and they all are well written by highly reputable specialists. Other chapters have been subjected to major or minor revisions. The paper and printing are of superior quality. The illustrations are generally good, but the color plates are much more attractive.

Epidemiologically oriented, the diseases are arranged by their common portals of entry. This arrangement may not be convenient to some readers. This book offers essential and practical information in lieu of complete coverage. Those diseases which are seldom seen in this country but are commonly encountered in foreign lands are less adequately covered. The appendix and glossary at the end of the text are highly useful.

In general, this book is to be highly recommended for both teaching and reference. Dr. Top should be congratulated for his unique experience in getting this big writing job so well done.

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PEDIATRIC THERAPY

Harry C. Shirkey, The C. V. Mosby Co., St. Louis, Mo., 2nd edition, 1966; 1223 pages; $18.50.

This is a large book in the "current" format put together by Dr. Shirkey and 84 contributors. Dr. Shirkey's background in pharmacy puts a broad pharmacologic base under this book, but there is still room for pediatric surgery and pediatric neurosurgery; and also pediatric psychiatry in the behavior disorder chapters and the chapter on enuresis.

Dr. Shirkey is also well-versed in photography, (and is indeed known for a collection — "Diagnosis by Inspection"). This know-how produces many good photographs, charts and art-work. First sections on fundamentals, general therapy and treatment of symptoms are especially good.

Following are more usual sections on treatment of newborns, infectious diseases and the various subspecialty sections. Two final sections concern poisoning and drug overdosages.

Gellis and Kagan have written the other standard in this field, *Current Pediatric Therapy*. Both are good. It would be difficult to choose between the two; pick *Pediatric Therapy* for a good basic pharmacologic background. The old joke about such books is that one can cure anything as long as he is on the correct page. Recognizing this is a *therapy* book, careful reading will also improve ones diagnostic acumen.

ALVIN J. HALEY, M.D.
Fort Wayne

THERAPEUTIC RADIOLOGY
Rationale, Technique and Results

William T. Moss, The C. V. Mosby Co., St. Louis, Mo., 2nd edition, 1965; 514 pages.

Therapeutic Radiology is a scholarly text that could be profitably read by anyone caring for patients who need or might potentially need radiation therapy. It is well balanced with reasons and results. The book is considerably improved over the first edition and shows maturation of judgment and a thorough familiarity with teaching, research and current practice.

We can recommend this book both as a text and as a reference in radiation therapy to those practicing the art without reservation as to whether they are beginners or mature therapists.

We know of no other book that is as comprehensive, short and easy to read on this subject.

J. L. MORTON, M.D.
Indianapolis

GONADOTROPINS
Physiochemical and Physiological Properties

Ciba Foundation Study Group No. 22, Little, Brown & Co., Boston, Mass., 1965; 125 pages; illustrated; $3.50.

The previously vague word, gonadotropin, is slowly being defined as at least four definite substances: (1) pituitary follicle-stimulating hormone (FSH), (2) pituitary luteinizing hormone (LH), (3) human chorionic gonadotropin (HCG) and (4) pregnant mares' serum gonadotropin (PMSG).

This study group dealt with the present status of research aimed at isolation, chemical identification and standardization of these substances. Mention is made of pending problems such as (1) CNS control of the biosynthesis (2) exact steric chemical formulae (3) simplification of the presently very complex and cumbersome analytical procedures, etc.

While all this is intriguing and — potentially — of the greatest possible practical interest, this booklet is *by* experts *for* experts in

the field. One must hope to live to see the problems solved and the results incorporated into easily accessible textbooks.

ARNOLD LIEBERMAN, M.D.
New York, N. Y.

Abstracts From Various Literature, Prepared by AMA

VALUE OF THE MATERNAL RHESUS-ANTIBODY TITER

J. W. Crawford (William Low House, 10 Dudhope Terrace, Dundee, Scotland), C. Cameron, and C. H. M. Walker.

Lancet 1:887-890, (April 23), 1966.

Two hundred deliveries have been analyzed to judge the place of antibody titration, amniocentesis, and intrauterine transfusion. The simplest and most important single investigation in Rh incompatability is the estimation of maternal antibody-titer. This may be supplemented in a number of cases (about a third) by amniocentesis as indicated by the history and titer level. In some cases amniocentesis may be repeated at intervals of two to three weeks. The most valuable treatment of hemolytic disease at present is premature delivery. In a small number of cases the history, titer and amniocentesis indicate that early death of the fetus is likely. Since induction of pregnancy is not applicable before 32 weeks and may be especially hazardous before 34 weeks if the baby is thought to weigh less than 4 lb., intrauterine transfusion is then necessary and often lifesaving. Intrauterine transfusion has offered a method of saving babies at a date earlier than premature induction can be used. The earlier the baby is affected, however, the less chance there is of success by this method. For the babies lost before 28 weeks, and even more before 24 weeks, there is still a need for a more effective form of treatment.

TRAUMATIC RUPTURE OF THE SPLEEN: A TEN-YEAR EXPERIENCE WITH 18 CASES

G. T. R. Fahlund (Geisinger Medical Center, Danville, Pa.) and W. P. Smedley

Amer. Surg. 32:325-328, (May), 1966.

In a ten-year study consisting of 18 cases of traumatic rupture of the spleen, blunt abdominal trauma was the most common cause, accounting for 13 cases. Abdominal pain was the most common symptom of rupture of the spleen. Other signs of splenic injury were peritoneal irritation, a rising pulse and a falling hematocrit. In this series, automobile accidents and falling were the most frequent causes of splenic rupture. The management of traumatic rupture of the spleen, be it immediate or delayed, is splenectomy with blood replacement.

REGIONAL ENTERITIS (CROHN'S DISEASE)

D. J. Fone (The Royal Hosp., Melbourne, Australia)

Med. J. Aust. 1:865-873, (May 21), 1966.

The clinical and pathological features of 41 cases of regional enteritis (Crohn's disease) are described. In 24 of these cases, the diagnosis has been established during the last five years. The characteristic tendency of Crohn's disease to occur predominantly in young adults, to involve the terminal part of the ileum most frequently, and to recur after surgical treatment was seen. The recurrence rate at the present time is approximately 50%. The outstanding pathological feature was one of chronic inflammation and fibrosis. Granulomatous lesions containing giant cells were seen in 10 cases; they are not considered essential for the diagnosis, although the examination of multiple sections will frequently reveal their presence. The colon was involved in seven cases. The major clinical features were recurring

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Dr. Priscilla Kincaid-Smith
Royal Melbourne Hospital
Melbourne, Victoria, Australia

Professor Malcolm D. Milne
Westminster Hospital Medical School
London, England

Professor H. D. De Wardener
Charing Cross Hospital Medical School
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Dr. John T. Grayhack
Northwestern University Medical School
Chicago, Illinois

Professor Jean Hamburger
Clinique Des Maladies Metaboliques
Hospital Necker
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In congestive heart-failure patients, AQUATAG (benzthiazide) produced the same weight loss, during a 48-hour treatment period as did a maximally effective dose of hydrochlorothiazide.

DOSAGE: Diuresis, initially 50 to 200 mg.; maintenance 25 to 150 mg., daily. Hypertension 50 to 100 mg. initially, adjusted to 50 mg. t.i.d. or downward to minimal effective dosage level.

WARNINGS: Use with caution in the presence of renal disease as azotemia may be precipitated or increased. In patients with advanced hepatic disease, electrolyte imbalance may result in hepatic coma. Dosage of coadministered antihypertensive agents should be reduced by at least 50%. In cases of suspected electrolyte imbalance, serum electrolyte determinations should be performed and imbalance, if any, corrected. Stenosis or ulcer of small intestine have been reported with coated potassium formulas, and surgery has been required and deaths have occurred. Based on surveys of both United States and foreign physicians, incidence of these lesions is low and a causal relationship in man has not been definitely established. Until further experience has been obtained, the use of the drug in pregnant patients should be weighed against possible hazards to the fetus.

CONTRAINDICATIONS: AQUATAG (benzthiazide) is contraindicated in progressive renal disease or dysfunction including increasing oliguria and azotemia. Continued administration of this drug is contraindicated in patients who show no response to its diuretic or antihypertensive properties. Severe hepatic disease is a relative contraindication. (See "Warnings" above.)

PRECAUTIONS AND SIDE EFFECTS: Electrolyte imbalance with hypokalemia (digitalis toxicity may be precipitated), hypochloremic alkalosis and hyponatremia may occur.

Patients with cirrhosis should be observed for impending hepatic coma and hypokalemia. Other reactions may include blood dyscrasias, hyperuricemia and gout, nausea, jaundice, anorexia, vomiting, diarrhea, dizziness, paresthesia, photosensitivity and headache. Hepatic fetor, tremor, confusion and drowsiness are signs of impending pre coma and coma in patients with cirrhosis. Insulin requirements may be altered in diabetes. AQUATAG (benzthiazide) should be used with caution post-operatively as hypokalemia is not uncommon. Potassium supplementation may be advisable pre- and post-operatively. There have been occasional reports of thrombocytopenia, leukopenia, agranulocytosis, aplastic anemia and precipitation of acute pancreatitis or jaundice.

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CARBOHYDRATE INTOLERANCE IN POSTGASTRECTOMY PATIENTS

P. D. Robertson (Department of General Practice, Edinburgh University, Edinburgh)

Arch. Intern. Med. 117:764-768, (June), 1966.

High peak or lag blood glucose curves may be found when oral glucose tolerance tests are done on subjects who have had a gastric operation for peptic ulcer. This phenomenon is attributed to jejunal absorption secondary to an accelerated transit from the stomach. However, when intravenous glucose tolerance tests, which are not dependent on intestinal absorption, were done on seven post-gastrectomy patients with lag curves, abnormal results in the diabetic range were obtained in six. The oral tests were conducted originally because of hypoglycemia symptoms in five patients and because of glycosuria in two. The difficulties of defining diabetes in terms of carbohydrate intolerance are discussed.

CONTROLLED STUDY OF OUTPATIENT GASTRIC FREEZING

M. C. Lubos, L. C. Viril, and A. P. Klotz (Department of Medicine, University of Kansas Medical Center, Kansas City)

Amer. J. Dig. Dis. 11:266-271, (April), 1966.

In a study of gastric freezing in 188 outpatients, placebo response was as good as response to the treatment itself, nor were results improved by addition of a modified and simplified postfreeze medical program.

THERAPEUTIC SUGGESTION: AN IMPORTANT PART OF HYPNOTIC MEDICATION

M. K. Benson, R. J. Cherry and A. Herxheimer (London Hosp. Medical College, London)

Lancet 1:1239-1240, (June 4), 1966.

Twelve medical students took chloral hydrate in an experiment to determine the extent of the hypnotic effect on the subject's knowing that the drug was a hypnotic. Chloral hydrate (1 gm) was given in two guises — one labeled "dream drug" and one labeled "sleeping drug." Estimates of the time taken to fall asleep and the length and depth of sleep showed no significant difference between these two pharmacologically identical treatments. However, the subjects assessed their sleep as more refreshing when they had taken chloral labeled "sleeping drug" than when they had taken the "dream drug." This finding underlines the importance of positive therapeutic suggestion in the use of hypnotics.

SIX CASES OF HYPERTENSIVE CRISIS IN PATIENTS ON TRANYLCYPROMINE AFTER EATING CHICKEN LIVERS

D. L. Hedberg, M. W. Gordon, and B. C. Glueck, Jr. (Institute of Living, Hartford, Conn.)

Amer. J. Psychiat. 122:933-937, (Feb.), 1966.

Chicken livers ingested by patients who were receiving the MAO inhibitor, tranylcypromine, gave rise to six serious hypertensive episodes and four moderately severe side reactions. Biochemical analysis of samples of chicken livers ingested by patients who showed adverse reactions showed the presence of approximately 100μg/gm of tyramine. Further investigation is needed to verify the hypothesis that patients on tranylcypromine and a phenothiazine who ingested liver were free of symptoms as a result of the protection afforded by the phenothiazine when prescribed with the MAO inhibitor at a given milligram ratio. ◄

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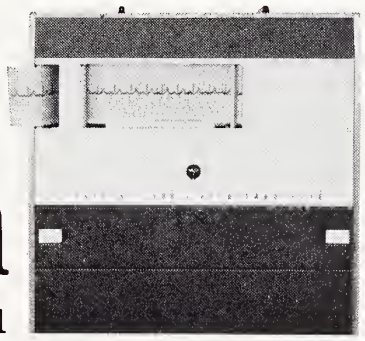
then 

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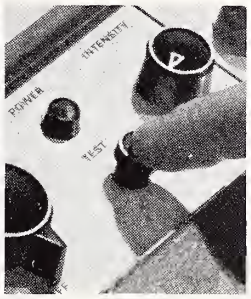

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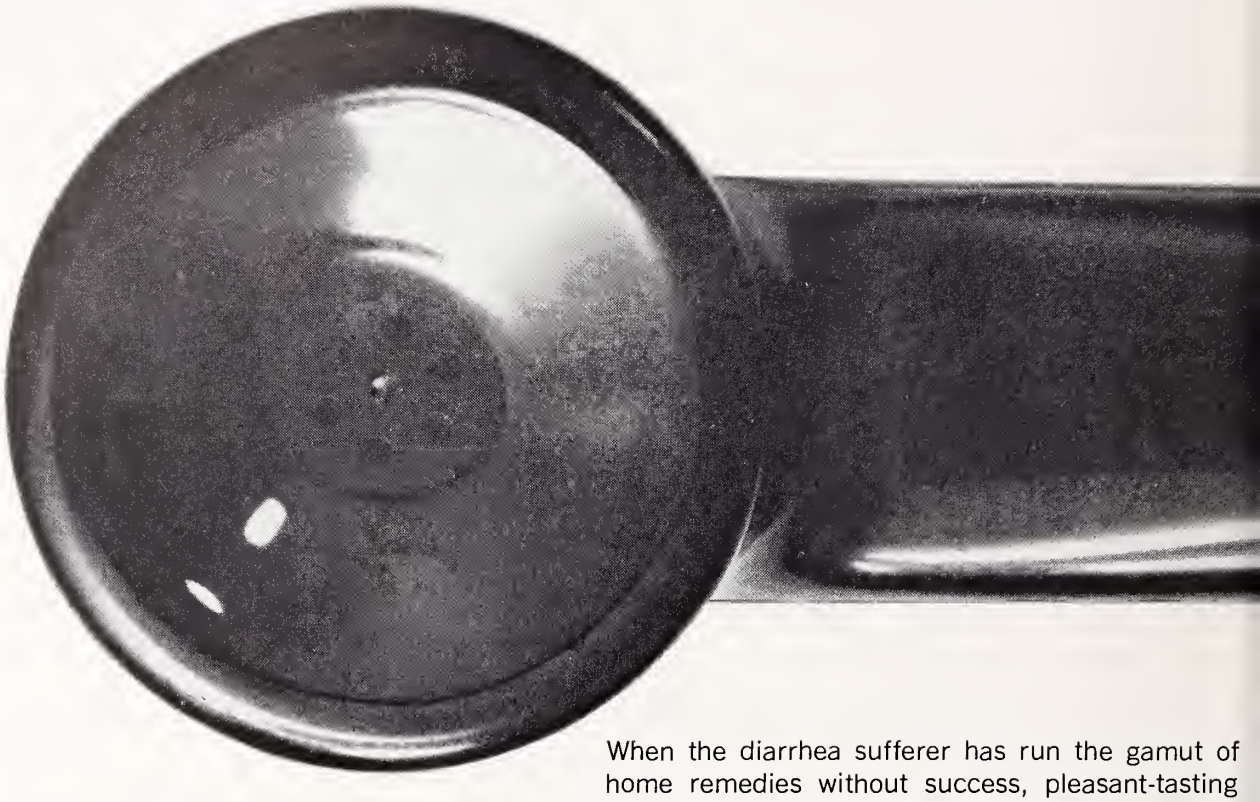
When uncontrolled diarrhea brings a call for help



When the diarrhea sufferer has run the gamut of home remedies without success, pleasant-tasting CREMOMYCIN can answer the call for help. It can be counted on to consolidate fluid stools, soothe intestinal inflammation, inhibit enteric pathogens, and detoxify putrefactive materials — usually within a few hours.

CREMOMYCIN combines the bacteriostatic agents, succinylsulfathiazole and neomycin, with the adsorbent and protective demulcents, kaolin and pectin, for comprehensive control of diarrhea.

INDICATIONS: Diarrhea.

CONTRAINDICATIONS: Do not use in intestinal obstruction, extensive ulceration of bowel, or diverticulosis; in hypersensitivity to sulfonamides or neomycin; in pregnancy at term, in premature infants, or during first week of life in the newborn.

WARNINGS: Use only after critical appraisal in patients with hepatic or renal damage, urinary obstruction, or blood dyscrasias. Fatal hypersensitivity reactions and blood dyscrasias reported with use of sulfonamides. Consider periodic blood counts, hepatic and renal function tests during intermittent or chronic use.

PRECAUTIONS: Succinylsulfathiazole: Use with caution if there is history of significant allergies and/or asthma. Continued use requires supplementary vitamins B_1 and K. *Neomycin:* Watch for

your ℞ for Cremomycin can provide relief

curare-like neuromuscular block during anesthesia if neomycin is used preoperatively in large doses when renal function is poor; watch for overgrowth of nonsusceptible organisms. Consider possibility of ototoxicity and nephrotoxicity with prolonged high dosage.

SIDE EFFECTS: As with all sulfonamides: Headache, malaise, anorexia, G.I. symptoms, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, rash, conjunctival and scleral injection, petechiae, purpura, hematuria, and crystalluria have been noted. Reduced fecal output of thiamine and decreased synthesis of vitamin K have been reported. *Neomycin:* Nausea, loose stools.

Before prescribing or administering, read package circular with product or available on request.

promptly relieves diarrheal distress

Cremomycin®

ANTIDIARRHEAL

Composition: Each 30 cc. contains neomycin sulfate 300 mg. (equivalent to 210 mg. of neomycin base), succinylsulfathiazole 3.0 Gm., colloidal kaolin 3.0 Gm., pectin 0.27 Gm.

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where today's theory is tomorrow's therapy

. . . The urine normally is a poison, and any stagnation renders it more poisonous. In the case of open hydronephrosis, associated with moveable kidney, with a constant cesspool of urine, so laden with poisons, retained within the body, evidences of chronic poisoning must occur. The central nervous system is most affected, the symptoms being severe headache, morbid fears, mental depression, melancholia and even insanity.

Also normal urine has a light bactericidal action, which is very rapidly lost when stagnation occurs; hence in this way any stasis renders the tissues more liable to bacterial invasion. Because of the universality of the dropped kidney, enough significance is not attached to this condition.

The principal factor contributing to this state of mind of the profession has been the inability to distinguish between the benign and the malignant ptosed kidney — the ptosed kidney that does not produce stasis and the one that does . . . . H. O. Mertz, M.D., LaPorte, "Uronephrosis: Its Significance and Detection," *JISMA*, Sept., 1916.

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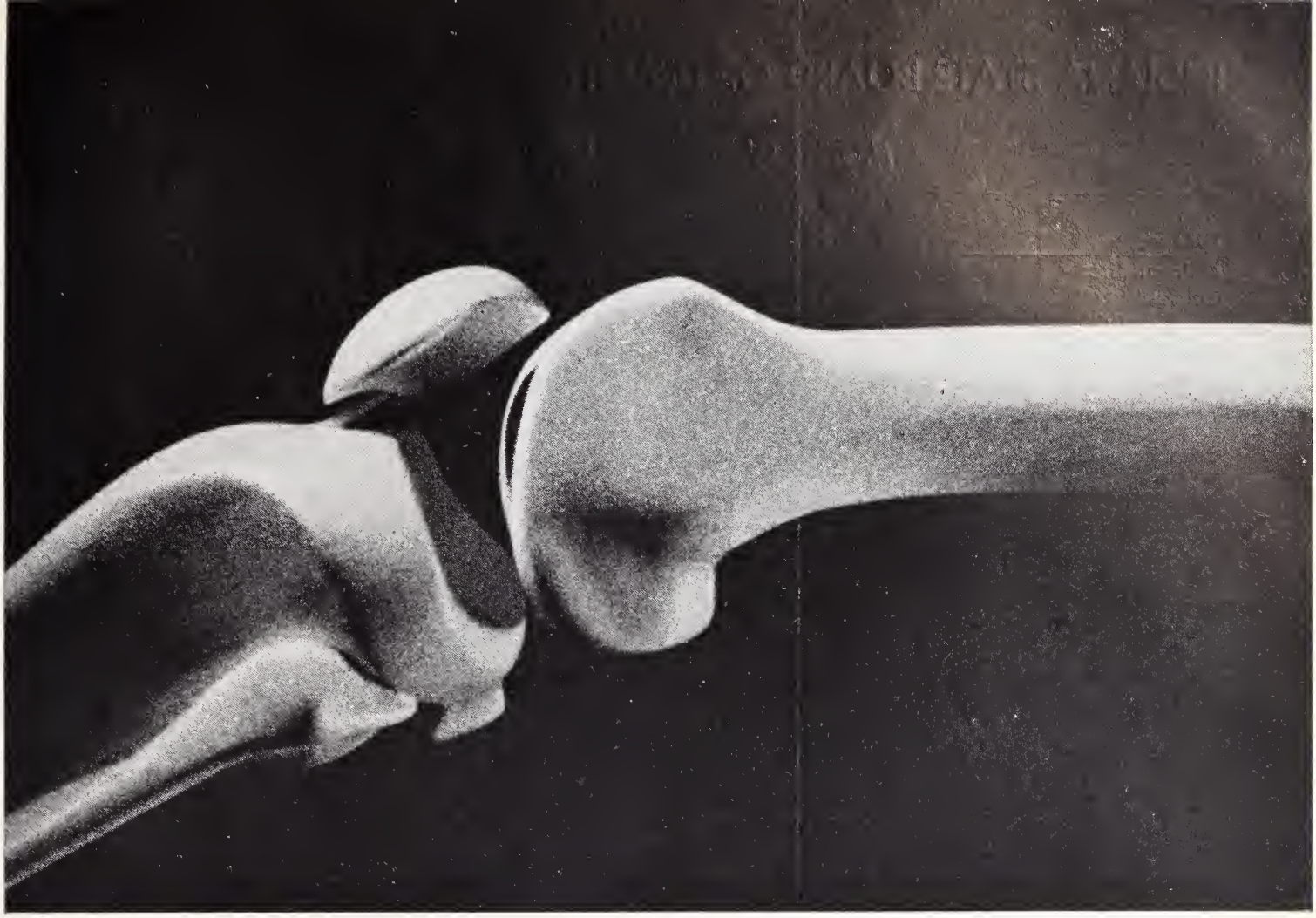

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phenylbutazone, 100 mg.
dried aluminum hydroxide gel, 100 mg.
magnesium trisilicate, 150 mg.
homatropine methylbromide, 1.25 mg.

Usually works within 3 to 4 days in osteoarthritis

The trial period need not exceed 1 week. In contrast, the recommended trial period for indomethacin is *at least 1 month.*

That's why it's logical to start therapy with Butazolidin alka—you'll know quickly whether or not it works. And usually, it will.

A large number of investigators have reported major improvement in about 75% of cases. Some patients have gone into remission. Relief of stiffness and pain may be followed quickly by improved function and resolution of other signs of inflammation. And Butazolidin alka is well tolerated, especially since it contains antacids and an antispasmodic to minimize gastric upset.

Contraindications
Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. Because of the increased possibility of toxic reactions, the drug should be used with greater care in the elderly and should not be given when the patient is senile or when other potent chemotherapeutic agents are given concurrently. Large doses of Butazolidin alka are contraindicated in patients with glaucoma.

Warning
If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

Use with caution in the first trimester of pregnancy.

Precautions
Before prescribing, the physician should obtain a detailed history and perform a complete physical and laboratory examination, including a blood count. The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made to guard against blood dyscrasias.

Adverse Reactions
The most common adverse reactions are nausea, edema and drug rash. Moderately lowered red cell count may sometimes occur due to hemodilution. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vertigo or languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects.

Confusional states, hyperglycemia, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

Dosage
The initial daily dosage in adults is 300-600 mg. daily in divided doses. In most instances, 400 mg. daily is sufficient. When improvement occurs, dosage should be decreased to the minimum effective level: this should not exceed 400 mg. daily, and is often achieved with only 100-200 mg. daily.

For complete details, please refer to full prescribing information.
6509-V(B)

Also available: Butazolidin®, phenylbutazone Tablets of 100 mg.

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INDIANA STATE BOARD OF HEALTH

MONTHLY REPORT—July, 1966

Disease	July 1966	June 1966	May 1966	July 1965	July 1964
Animal Bites	967	1476	1135	1077	1304
Chickenpox	75	196	344	110	125
Conjunctivitis	85	131	140	96	181
Diphtheria	0	0	1	0	1
Dysentery, Unspecified	44	37	33	40	58
Gonorrhea	338	497	303	317	367
Impetigo	130	86	65	156	252
Infectious Hepatitis	30	28	30	47	46
Infectious Mononucleosis	45	48	52	38	45
Influenza	112	360	869	205	217
Measles (Rubeola-Rubella)	322	1241	1681	144	548
Meningitis, Meningococcic	1	8	16	3	3
Meningitis, Other	4	6	5	3	4
Mumps	81	309	250	116	270
Pertussis	32	5	18	10	79
Pneumonia	153	419	607	124	135
Poliomyelitis	0	0	0	0	1
Streptococcal Infection	238	513	606	421	513
Syphilis					
Primary and Secondary	9	9	14	1	7
All Other Syphilis	86	119	95	81	126
Tinea Capitis	5	4	4	16	6
Tuberculosis (Active)	83	102	76	75	135

SCIENTIFIC EXHIBIT APPLICATION FORM

Committee on Scientific Exhibits
Indiana State Medical Association
3935 N. Meridian Street
Indianapolis, Indiana 46208

Please send me an application form for a Scientific Exhibit at the ISMA Annual Convention, October 10-13, 1966, French Lick, Indiana.

I propose to exhibit_____

_____

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Name_____

Address_____

City_____

State_____

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two years
there's been
one new case
of active tuberculosis
reported for every
four thousand
of U.S. population.

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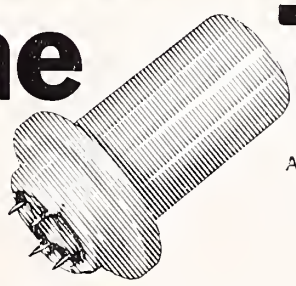
Tuberculin, Tine Test



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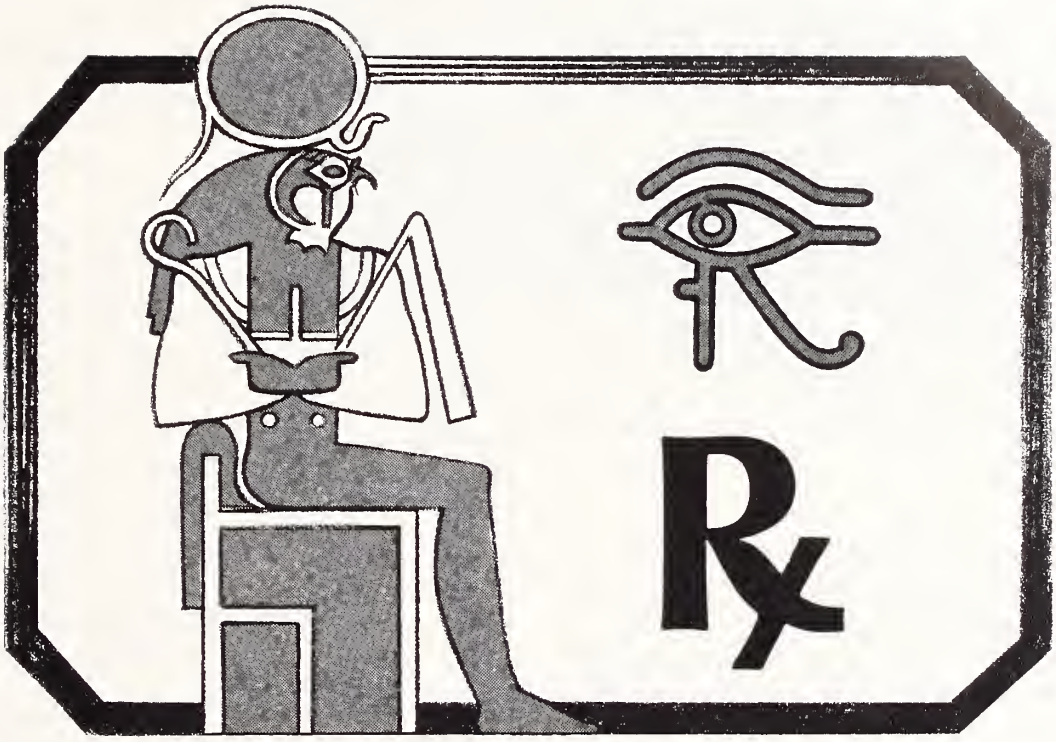

PROGRESS

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Drug Manufacturer Offers Film and Rating Scales on Measurement of Depression

A medical motion picture film entitled "Measurement of Depression" has been developed and produced by Lakeside Laboratories for use by hospital staff societies, county medical societies and other professional groups. It is on 16 mm. film, has sound and color, and runs 22 minutes.

The film explains the use of self-rating scales, a supply of which accompanies the film, for the determination by a physician of the degree or presence of depression. The concept was originally offered by a psychiatrist, Dr. William W. K. Zung, in *The Archives of General Psychiatry*.

Arrangements for use of the film, free of charge on a loan basis, and for a supply of the rating scales, may be made by writing Medical Film Department, Lakeside Laboratories, 1707 E. North Ave., Milwaukee, Wisconsin 53201.

Wins Medical Fellowship

Joseph M. Davie of LaPorte, Indiana, a student at Washington University of St. Louis, Missouri, is the recipient of one of the Medical Scientist Fellowships granted by the Life Insurance Medical Research Fund. The fellowships provide for up to six years' training, leading to the M.D. degree and the Ph.D. or its equivalent.

Auto Purchase Plan Announced For Residents and Interns

The National Association of Residents and Interns, 41 E. 42nd St., New York City, announced today that it has made arrangements for its members to purchase new automobiles at $100.00 over the dealer's actual delivery cost. Most optional accessories, such as air conditioning, power packs, white wall tires and other usually expensive items are made available at the dealer's actual cost.

This program is now available in New York, Chicago and Los Angeles, and it is expected that it will shortly be expanded to cover the entire country.

In the first three weeks of operation through the program, some 60 automobiles were sold to members of this association. Savings have run anywhere from $400 to $750 per car. Mr. George Arden, the Executive Director of the association, states that this is the first time that a program of this sort has been made available, and he feels that it will be most advantageous to the members of N.A.R.I. because some 27% to 28% of all residents and interns own automobiles.

All American makes and models are available through the program, and many foreign cars. Delivery is usually three to four weeks, and the physician purchaser has his choice of style, trim, make and model, just as if he were purchasing the car through a local dealer.

Surgeon General's Term Extended

Lt. Gen. Leonard D. Heaton's term as Surgeon General of the Army has been extended for the third time since he originally assumed office in 1959. His tour of duty will now extend to December 1, 1968.

Smith Kline & French Foundation Reports Contributions in Excess of $1,000,000

The Smith Kline & French Foundation reports contributions in excess of $1,000,000 during the past year. Since its inception in 1953, the Foundation has given in excess of $8,000,000.

Recipients of matching gifts for education in Indiana included Indiana University, Butler University, Goshen College, DePauw University, Purdue University and the University of Notre Dame. Indiana University Medical Center received $5,000 in support of a medical center program under the direction of Provost Kenneth E. Penrod.

New A. H. Robins Company Manager

Thomas Doherty has been named manager of the Michigan Division of A. H. Robins Company. The "Michigan" Division consists of all of Michigan except the upper peninsula, plus small portions of Indiana and Ohio. Mr. Doherty will live in Detroit.

New Pamphlet on Epilepsy Now Available to Physicians, Patients

"Epilepsy — Today's Encouraging Outlook," a Public Affairs pamphlet produced in cooperation with the Epilepsy Association of America, is written for instruction and orientation of the public.

Its theme is "With Drugs and Healthful Daily Regimen, More and More Epileptics Lead Normal Lives." The 28-page pamphlet may be obtained at 25 cents a copy and with discounts for quantities from Public Affairs Pamphlets, 381 Park Ave., South, New York City, 10016.

Dr. Ginsberg Appointed

Dr. Stewart T. Ginsberg, Commissioner of Mental Health for Indiana from 1957 to this year, has been appointed director of the Veterans Administration hospital at Lyons, New Jersey.

Three Booklets on Arthritis Published By U.S. Public Health Service

As a part of a major effort to combat the crippling effects of arthritis, the U. S. Public Health Service has published three booklets on the subject.

One is "Report: Surgeon General's Workshop on Prevention of Disability from Arthritis." Another booklet is "Highlights of the Report" and contains conclusions and recommendations of seven expert workshop groups. The third booklet is an "Arthritis Source Book" which contains a wide range of data on the many aspects of arthritis.

The booklets are on sale by the Superintendent of Documents, Washington, D.C. 20402. Prices are: Report — 75 cents; Highlights — 20 cents; and Source Book — 50 cents.

CITATIONS for "achievement" from the AMA-ERF were awarded to Oregon, Indiana, California and Montana medical associations for the highest total dollar amount contributed to the foundation in 1965. Dr. Raymond M. McKeown (center), Coos Bay, Ore., foundation president, made the presentations to (left to right) Drs. Max H. Parrott, Portland, Ore. Guy A. Owsley, Hartford City, Ind.; Burl L. Davis, Palo Alto, Calif., and S. C. Pratt, Miles City, Mont. [We regret that the award winners were incorrectly identified in last month's Journal.]

Association of American Physicians And Surgeons Sponsors Essay Contest

The Association of American Physicians and Surgeons is sponsoring its 21st Annual National Essay Contest with $2,675.00 in national prizes.

County and state medical societies and auxiliaries are invited to co-sponsor local contests. Details may be obtained by writing the Association at 185 N. Wabash Ave., Chicago 60601.

Dr. Wing Named to AMA Committee

Dr. Herman Wing, of Gary, has been appointed a member of the AMA Committee on Medicolegal Problems. Dr. Wing is the new alternate councilor of the 10th District of the Indiana State Medical Association.

New Society for Cryo-ophthalmology Formed

The Society for Cryo-ophthalmology has been formed to promote investigative and clinical applications of low-temperature technics to the eye.

Applications for membership will be welcomed from those interested in the investigative aspects of this subject, the preservation of ocular tissue, therapeutic applications of cryogenics to various ocular diseases, and cryosurgical technics. It is contemplated that scientific meetings will be held immediately prior to the annual sessions of the American Academy of Ophthalmology and Otolaryngology.

Inquiries and applications should be addressed to Dr. John G. Bellows, 30 N. Michigan Blvd., Chicago 60602.

Miss Rachel Lehman Named Indiana's Outstanding Medical Technologist

Miss Rachel Lehman, Indianapolis, has been named Indiana's outstanding medical technologist by the national convention of the American Society of Medical Technologists.

Miss Lehman, technologist and instructor at the Indiana University Medical Center, received an award of merit from Corning Glass Works at the convention in Los Angeles recently.

Dr. Kirtley Elected Chairman

Dr. William R. Kirtley, Indianapolis, was elected chairman of the American Diabetes Association's Assembly of State Coordinators and Affiliate Delegates at the recent annual meeting. Dr. Kirtley will also serve on the association's board of directors.

Dr. Gardner Goes To London

Dr. Austin L. Gardner, Indianapolis, will be away from private practice for one year while he engages in study of vascular surgery at St. Mary's Hospital, London, England. He plans to reopen his office in August, 1967.

Dr. Miller Named Vice-President

Dr. Hugh A. Miller, Jr., graduate of Indiana University School of Medicine, has been appointed Vice-president, Research and Medical Affairs, for Miles Laboratories.

Dr. Miller practiced internal medicine in Elkhart for 11 years and has been with Miles as Associate Medical Director since July, 1962.

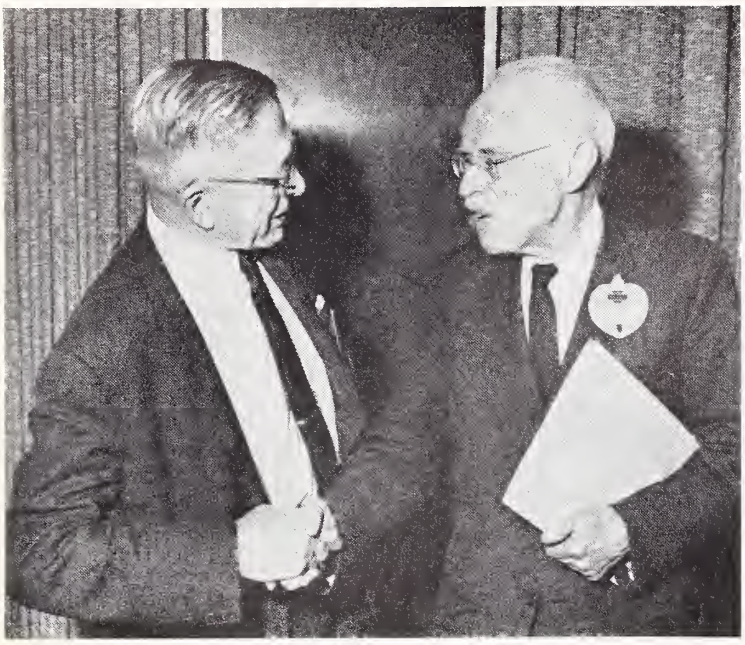
Dr. Clammer Named Director

Dr. George R. Clammer, formerly on the staff of the Indianapolis VA Hospital, and director of the Fort Wayne VA Hospital in 1961, has been named director of the Portland, Oregon, VA Hospital.

Award for Best Manuscript by Medical Student, Intern or Resident

A competition for a $250 award for the best manuscript submitted by a medical student, intern or resident on any subject pertinent to and concerning occupational health has been announced by the Central States Society of Industrial Medicine and Surgery. The contest closes at midnight on December 31, 1966.

Continued



DR. JAMES O. RITCHEY, (left) distinguished service professor of medicine emeritus at the Indiana University School of Medicine, exchanges remarks with Dr. Paul Dudley White, Boston cardiologist, at the annual luncheon meeting of the Marion County Heart Association in Indianapolis. Dr. Ritchey received a special recognition award from the Heart Association, the highest honor bestowed by that organization for "his years of devotion to the medical profession, his influence on medical students, his particular competence in the field of heart and cardiovascular diseases, and his many contributions to the community." Dr. White, internationally famous for his work in the field of heart disease, was the major speaker for the occasion. The Indiana State Medical Association's Seventh District combined its annual meeting with the Heart Association session.

A second competition, open only to residents in occupational medicine, is announced by the Industrial Medical Association. The award, consisting of an embossed scroll, will be presented at the association's annual meeting to the author or authors of a paper published in the open literature on a subject germane to occupational medicine which is judged to be the most outstanding of those submitted. Reprints entered in the competition must be published during 1966 and submitted prior to January 15, 1967.

Both contests will be judged by members of the Committee on Merit in Authorship of the Industrial Medical Association. The criteria will be largely based on clarity, validity, objectivity, originality and style. Complete contest rules may be obtained from: Industrial Medical Association, 55 E. Washington St., Chicago, Ill. 60602.

Dr. Dyken Heads Research Unit

Dr. Mark L. Dyken, Indianapolis, associate professor of neurology at I. U. School of Medicine, will be the principal investigator and director of a new clinical research facility to study the causes of various types of cerebral vascular disease. The U.S. Public Health Service is providing a three-year grant of $600,000 for this purpose.

New I.U. Business Manager

Arthur D. Lautzenheiser has been named Indiana University business manager for Indianapolis. Mr. Lautzenheiser has been assistant dean of the School of Medicine and liaison business officer for the Medical Center.

He will be responsible for all the supporting services at the Medical Center, including accounting, personnel, housekeeping, purchasing, housing, Student Union, bookstore, telephone, mail, printing and real estate. Creation of the new post is a step in the long range move to consolidate all Indianapolis divisions of Indiana University in an expanded campus in and near the Medical Center. ◄

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F. H. Spurlock, M.D.	92-2441
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Clinical Psychologist

Mrs. Margaret Keedy, A.C.S.W.
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James Jones, B.P.E.
Director of Activity Therapy

Donald R. Kinzer, Hospital Administrator

Admissions are arranged through referral to any active staff psychiatrist.

All general medical and surgical specialties in the community are available through physicians on the open consulting staff.

MOLECULAR REMODELING—

laboratory exercise or clinical necessity?

More than twenty-five years have passed since the discovery of the diuretic activity of sulfanilamide started pharmacologists on a succession of molecular remodelings to find the ideal diuretic.

Diuresis—a sought-after clinical effect from an unwanted side effect

It started in 1937 when a clinician reported that the administration of a sulfonamide was sometimes accompanied by an unexplainable side effect—metabolic acidosis.[1] Three years later the side effect was explained. The sulfonamide radical of sulfanilamide inhibited carbonic anhydrase,[2] the enzyme responsible for converting carbon dioxide and water to hydrogen ions and bicarbonate ions.

Later, other investigators showed by dog experiments that metabolic acidosis probably resulted when the inhibition of carbonic anhydrase upset the exchange of hydrogen and sodium ions, causing increased excretion of sodium as the bicarbonate.[3]

It was twelve long years after the first report of the unexplainable side effect (metabolic acidosis) that it was finally shown that large doses of sulfanilamide administered to edematous patients were indeed capable of promoting diuresis.[4] However, the possibility of toxic effects from its prolonged use and its relatively weak diuretic action made it impractical for clinical use as a diuretic.[5]

Because the inhibition of carbonic anhydrase seemed to be the key to effective diuresis, investigators began to look for more potent enzyme inhibitors —in the hopes that they would be more effective diuretics.

The most important of these early compounds, acetazolamide, enjoyed several years of fairly wide clinical use.

Its carbonic anhydrase inhibitory activity was several hundred times greater than that of sulfanilamide.[6] The increase in inhibitory activity, however, increased not only the excretion of sodium and bicarbonate ions, but also the excretion of potassium.[7] And, like its predecessor, acetazolamide precipitated mild acidosis. Its prolonged use could result in hypokalemic acidosis.[7]

The 'thiazides'—an answer to the metabolic acidosis caused by carbonic anhydrase inhibition

Despite the fact that the sulfonamide group appeared to be responsible for carbonic anhydrase inhibition which in turn appeared to be responsible for diuresis, investigators began to synthesize compounds with structural alterations to the sulfonamide group.

The first major breakthrough came with the synthesis of chlorothiazide. Altering the sulfonamide group did indeed alter the ability of chlorothiazide to inhibit carbonic anhydrase—it was only 1/10th as potent as acetazolamide in inhibiting the enzyme.[8] Despite the drop in inhibitory potency, however, chlorothiazide proved to be an effective diuretic—an observation that led to the conclusion that its diuretic action was due to some mechanism other than its action on carbonic anhydrase.[9,10]

For effective diuresis, chlorothiazide was administered in daily dosages ranging from 250 to 2000 mg.[11] It increased the excretion of sodium and chloride; and, to a lesser extent, potassium and bicarbonate.[11] The excretion of potassium appeared to be maximal at higher dose levels at which, theoretically, the carbonic anhydrase inhibitory effect is more active.[11] Its prolonged use, therefore, could sometimes result in metabolic hypokalemic, hypochloremic alkalosis.[7]

Naturetin—effective diuresis with more favorable electrolyte balance

Other thiazides followed—with improvements being aimed at two particular areas: 1. attempts to increase diuretic action in relation to the milligram potency of the drug, and 2. attempts at a more favorable sodium/potassium ratio in the urine, i.e., to decrease the excretion of potassium while maintaining the excretion of sodium.[12]

One of these, Naturetin, Squibb Bendroflumethiazide, has made advances on both these points. "By adding a 3-benzyl radical to hydroflumethiazide a rather dramatic reduction in dose range is accomplished. With this drug, effective sodium excretion is obtained with doses between 2.5 and 10 mg., which is a 200 to 1 ratio as compared to chlorothiazide..."[13]

Moreover, due probably to its virtual lack of carbonic anhydrase inhibition, Naturetin (bendroflumethiazide) has been shown to cause less potassium and bicarbonate loss and less alteration in urinary pH than either chlorothiazide or hydrochlorothiazide.

Naturetin is outstandingly effective not only in establishing, but also in maintaining, excretion of retained fluid in edematous patients. And its duration of action is sufficiently prolonged to allow a single daily administration in most patients. Naturetin is also an effective antihypertensive agent.

Contraindications: Severe renal impairment; previous hypersensitivity.

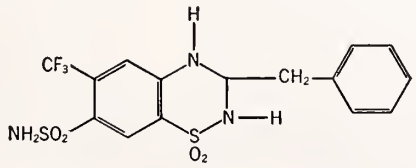
Warning: Ulcerative small bowel lesions have occurred with potassium-containing thiazide preparations or with enteric-coated potassium salts supplementally. Stop medication if abdominal pain, distension, nausea, vomiting, or G.I. bleeding occur.

Precautions: The dosage of ganglionic blocking agents, veratrum, or hydralazine when used concomitantly must be reduced by at least 50% to avoid orthostatic hypotension. Electrolyte disturbances are possible in cirrhotic or digitalized patients.

Side Effects: Bendroflumethiazide may cause increases in serum uric acid, unmask diabetes, increase glycemia and glycosuria in diabetic patients and may cause hypochloremic alkalosis, hypokalemia; cramps, pruritus, paresthesias, and rashes may occur.

Supplied: Naturetin (Squibb Bendroflumethiazide) 5 mg. and 2.5 mg. tablets. Also available Naturetin c̄ K [Squibb Bendroflumethiazide (5 or 2.5 mg.) with Potassium Chloride (500 mg.)]. For full information, see Product Brief.

References: **1.** Southworth, H.: Proc. Soc. Exper. Biol. & Med. *36*:58, 1937. **2.** Mann, T. and Keilin, D.: Nature *146*:164, 1940. **3.** Pitts, R. F., and Alexander, R. S.: Am. J. Physiol. *144*:239, 1945. **4.** Schwartz, W. B.: New England J. Med. *240*:173, 1949. **5.** Friedberg, C. K., in Moyer, J. H., and Fuchs, M.: Edema Mechanisms and Management, Philadelphia, W. B. Saunders Co., 1960, p. 259. **6.** Cumming, J. R.; Tabachnick, E., and Seelig, M., in Moyer, J. H., and Fuchs, M.: op. cit., p. 254. **7.** Werko, L., in Moyer, J. H., and Fuchs, M.: op. cit., p. 188. **8.** Beyer, K. H., Jr., in Moyer, J. H., and Fuchs, M.: op. cit., p. 274. **9.** Maren, T. H., and Wiley, C. E.: J. Pharmacol. & Exper. Therap. *143*:230, 1964. **10.** Earley, L. E., and Orloff, J.: Ann. Rev. Med. *15*:149, 1964. **11.** Fuchs, M., and Mallin, S. R., in Moyer, J. H., and Fuchs, M.: op. cit., p. 276. **12.** Ford, R. V., in Moyer, J. H., and Fuchs, M.: op. cit., p. 290. **13.** cited in Fuchs, M., and Mallin, S. R. (ref. 11): op. cit., p. 283.



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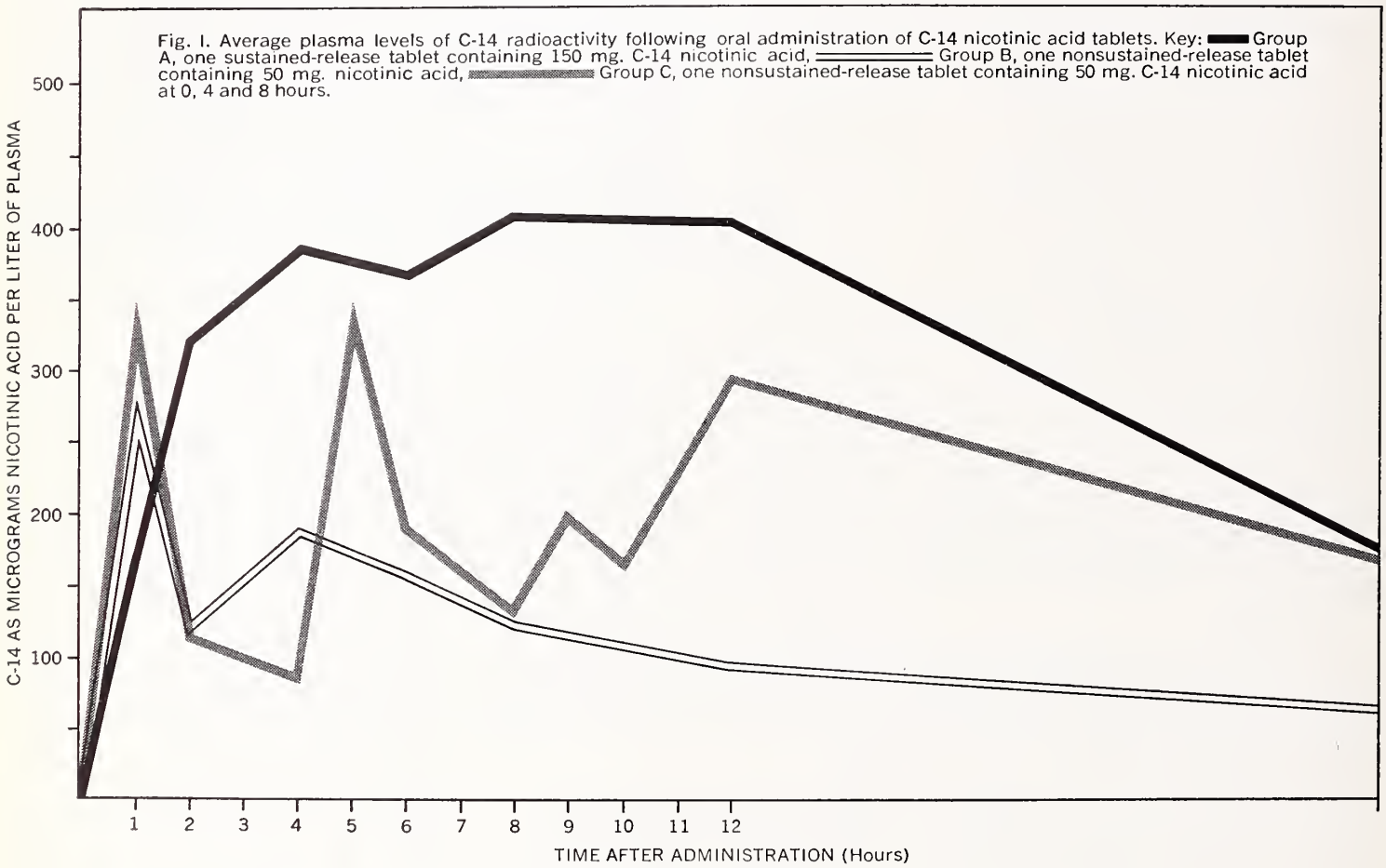


(fewer absent doses by absent-minded patients)

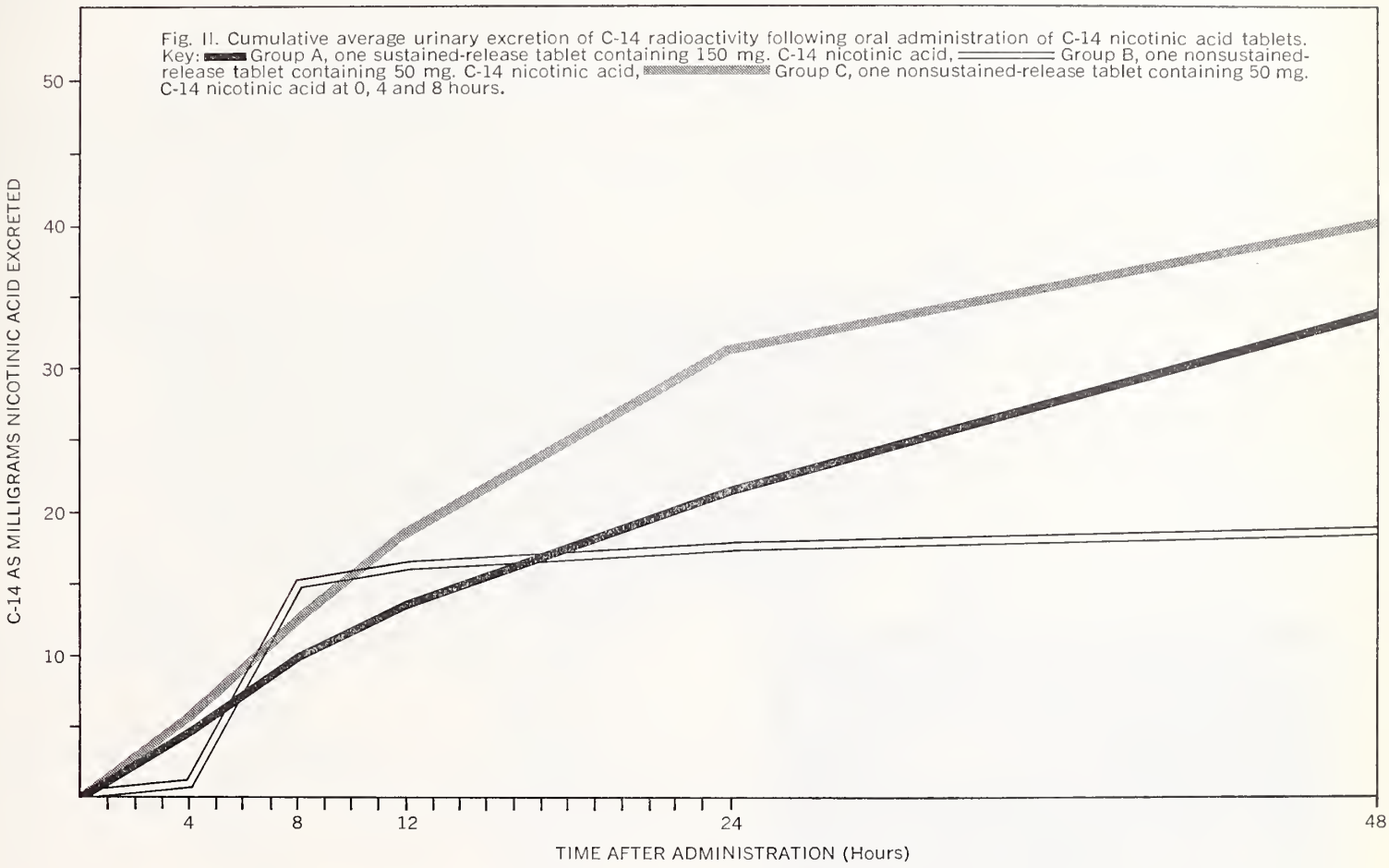
Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be continuous on a daily dose of only one Geroniazol TT tablet every 12 hours.

The gradual release of nicotinic acid in Geroniazol TT will provide the well-known peripheral vasodilatation needed in patients with deficient circulation and with a minimum amount (if any) of "flushing." Also, cerebrovascular circulation is complemented by pentylenetetrazol, long-established as a cerebral and respiratory stimulant.

Geroniazol TT improves the typical, unfortunate, signs of senile confusion. Patients become more alert,

aged and debilitated



less confused and moody. Personal care, memory, emotional stability, social attention improve. Fatigue, apathy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will permit your patients to enjoy the benefits of time-prolonged nicotinic acid/pentylenetetrazol therapy, at an economical price. Dosage is only one tablet every 12 hours.

Contraindications: There are no known contraindications.

Precautions: Exercise caution when treating patients with a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

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FIFTH GOVERNOR'S CONFERENCE ON AGING WILL BE OCTOBER 4-5 AT LAFAYETTE

The Indiana Commission on the Aging and Aged will hold its Fifth Governor's Conference on Aging at Purdue University, Lafayette, on October 4-5, 1966. This will be known as the Governor's Sesquicentennial Conference on Aging and it appears likely that the Governor will speak at the luncheon on Tuesday, October 4.

Advanced registrations are sought. The theme for the conference is "The Counseling of the Older Person." The need for counseling of older persons in a wide variety of areas is so obvious that it does not need to be defended. The members of our organization are interested in preparing those who work with us for retirement and for meaningful living after retirement. Attendance at this conference would give you a somewhat comprehensive idea of what is involved in working for meaningful living for older people.

We suggest you give consideration to attending this conference. If you find you can attend, write the Conference on Aging, Comptroller's Office, U. E. A. Room 110, Memorial Center, Purdue University, Lafayette, Indiana, for registration forms.

Marion County General Hospital Announces Postgraduate Courses

Postgraduate courses at the Marion County General Hospital are announced as follows:

1. Practical Management of the Arthritides, September 28, 1966.
2. Management of Psychiatric Emergencies, November 30, 1966.
3. Management of Cardiac Emergencies with Special Emphasis on Recent Advances in Electrotherapy, January 25, 1967.
4. Outpatient Chest Diseases, March 29, 1967.
5. Management of Common Dermatologic Conditions, May 3, 1967.

All courses have been approved by the American Academy of General Practice. Physicians in Indiana will receive further details by mail.

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Basic and Advanced Psychiatric Courses Offered General Practitioners

To meet the growing need for further training and experience in the areas of psychiatric diagnosis and treatment for general practitioners and physicians other than psychiatric specialists, basic and advanced courses will again be offered by the Department of Psychiatry and Neurology of The Chicago Medical School.

The aim of the postgraduate program is to increase the skills of the physician in the diagnosis and treatment of his general patient case load and in the management of the psychiatric problems which require limited goal therapy.

Courses will be offered beginning October 5, 1966. There is a limited enrollment, and advance registration is required. If you are interested in enrolling, please write to Director—Continuing Education, Department of Psychiatry and Neurology, The Chicago Medical School at Mount Sinai Hospital, 2755 W. 15th St., Chicago, Ill. 60608.

"Digitalis in 1966" Conference to Be October 6-7 at I.U. Medical Center

"Digitalis in 1966" will be the subject of a conference to be held at Indiana University Medical Center in Emerson Hall on October 6 and 7.

Enrollment is limited; advance registration is requested. The fee is $35. The University of Kentucky School of Medicine, Marion County General Hospital, the Krannert Heart Research Institute and the Indiana Heart Association are cooperating in the presentation.

Write Kalman Greenspan, Ph.D., Marion County General Hospital, Indianapolis 46207.

Harvard Medical School Offers Postgraduate Course on Cancer Treatment

Harvard Medical School will conduct a postgraduate course in Diagnosis and Treatment of Cancer on November 9, 10 and 11, at the Massachusetts General Hospital.

Attendance will be limited to 55. The fee is $105. Apply to Assistant Dean, Courses for Graduates, Harvard Medical School, 25 Shattuck St., Boston 02115.

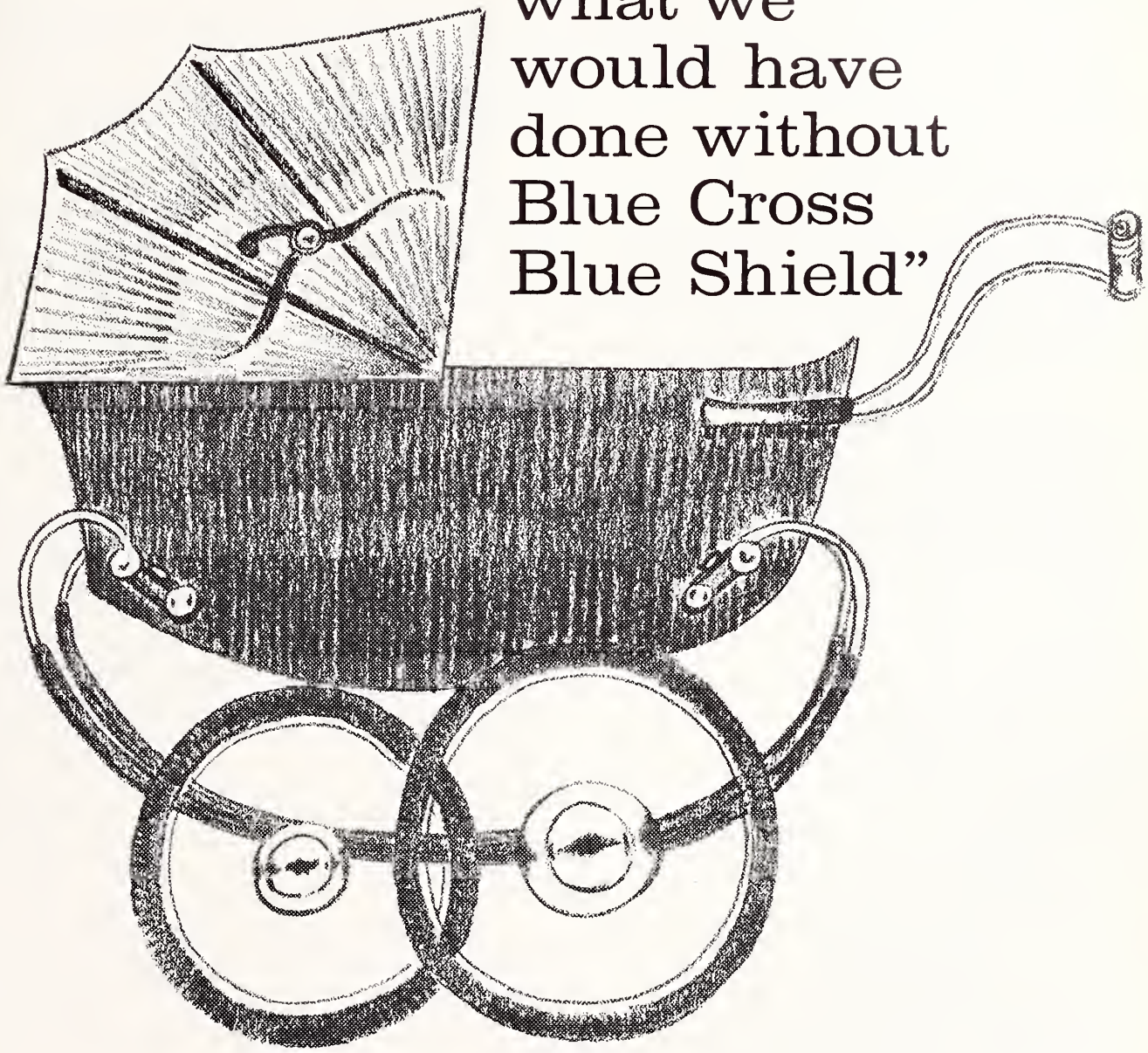
10th Annual Meeting Set for Medical Assistants Association

The 10th Annual Meeting of the American Association of Medical Assistants will be held in St. Louis at the Chase-Park Plaza Hotel, on October 19 to 23.

The role of the medical assistant in medicare and the drug abuse law will be the principal topics of discussion. Approximately 600 members are expected to attend.

Continued

"I don't know what we would have done without Blue Cross Blue Shield"



Young parents on a budget (like so many other people) say the same thing: "I don't know what we would have done without Blue Cross-Blue Shield." Their joy of a new arrival was not clouded by worries about hospital and doctor bills.

Any employer of young fathers would have some nice words for Blue Cross-Blue Shield membership, too. For this is the one health care plan that deals directly with hospitals and doctors—that takes care of the paperwork quickly and efficiently, keeps employers out of the claims-handling business.

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Postgraduate Course in Gastroenterology October 27-29

A postgraduate course in gastroenterology will be conducted by the American College of Gastroenterology in Philadelphia on October 27, 28 and 29. The fee for non-members is $60.

Address the College at 33 W. 60th St., New York City, 10023 for details and registration forms. The course will cover advances, of both medical and surgical nature, in diagnosis and treatment of gastrointestinal diseases.

Third National Congress on Medical Quackery October 7-8

The Third National Congress on Medical Quackery will be held on October 7 and 8, in Chicago, at the Pick-Congress Hotel under the sponsorship of the AMA and the National Health Council.

The basic purpose of the meeting is to promote public education on the folly and uselessness of all forms of worthless treatment. Dr. James L. Goddard, commissioner of the FDA, will be one of the speakers.

American Cancer Society Will Conduct Annual Scientific Session May 3, 1967

The American Cancer Society will conduct its annual scientific session at the Sheraton-Dallas Hotel in Dallas on May 3, 1967. The theme of the meeting will be "Current Concepts in Etiology and Diagnosis of Cancer."

Members of ISMA are all invited and are urged to attend. There is no registration fee. Copies of the program may be obtained by writing the Society at 219 E. 42nd St., New York City 10017.

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Symposium on Skin Diseases Common To Man and Animal will be November 2

A symposium on Skin Diseases Common to Man and Animals will be held on November 2, in Palm Springs, California, at the El Mirador Hotel.

Co-sponsors are the Committee on Cutaneous Health and Cosmetics of the American Medical Association and the American Animal Hospital Association. Fee for registration and lunch is $10.00.

Programs and registration forms may be obtained by writing the AMA Committee at 535 N. Dearborn, Chicago 60610.

36th Annual Fall Conference of Oklahoma City Clinical Society in October

The Oklahoma City Clinical Society will open its 36th annual three-day conference at the Sheraton-Oklahoma Hotel on October 25, 1966.

An outstanding program of postgraduate teaching has been arranged for the three-day program. This includes lectures and discussions by 14 distinguished speakers selected from various medical and teaching centers throughout the United States.

Dr. Raleigh E. Lingeman, Indianapolis otolaryngologist, will be one of the guest speakers.

In addition to the outstanding all day seminar on Diabetes Mellitus, scheduled for Tuesday, October 25, this year's program format will also include closed circuit color TV programming. From 9 a.m. to 10 a.m. on October 24, 25, 26, live clinics on closed-circuit TV will be presented in the auditorium. These programs, under the direction of Dr. Don H. O'Donoghue in orthopedics-rheumatology, Dr. Mark A. Everett in dermatology, and Dr. Joseph W. Kelso in obstetrics and gynecology, will feature emphasis on practical office procedures and technics.

The faculty of the University of Oklahoma School of Medicine will present a special program Wednesday afternoon, October 26. Outstanding teachers on the faculty have been selected to present a program entitled, "What's New and What's Useable Clinically of What's New."

A cordial invitation is extended to all physicians who are members of their county medical societies to attend this meeting. Registration fee is $25.00 which includes all features, plus luncheons and banquet. For further information, write: Mrs. Alma O'Donnell, Executive Secretary, Oklahoma City Clinical Society. 2809 Northwest Expressway, Oklahoma City, Oklahoma 73112.

Annual Otolaryngologic Assembly Will be October 1-7 at Chicago

The Annual Otolaryngologic Assembly of 1966 will be held October 1 through 7 in the new Illinois Eye and Ear Infirmary at the Medical Center, Chicago.

The Department of Otolaryngology of the College of Medicine of the University of Illinois offers a condensed postgraduate basic and clinical program for practicing otolaryngologists. It is designed to bring to specialists current information in medical and surgical otorhinolaryngology.

Interested physicians should direct communications to: Department of Otolaryngology, P. O. Box 6998, Chicago, Illinois 60680.

Technicon International Symposium on Automation to be October 17-19

The Technicon International Symposium on Automation in Analytical Chemistry will be held at the Statler-Hilton Hotel, New York City, on October 17, 18 and 19.

Write Jerome E. Golin, Technicon Instruments Corporation, New York City 10502 for further information.

Laryngology, Bronchoesophagology Course October 31 to November 12

The Department of Otolaryngology of the Illinois Eye and Ear Infirmary and the College of Medicine of the University of Illinois at the Medical Center, Chicago, will conduct a postgraduate course in laryngology and bronchoesophagology from October 31 through November 12.

This course is limited to fifteen physicians and will be under the direction of Paul H. Holinger, M.D. It will be held largely at the new Illinois Eye and Ear Infirmary, 1855 West Taylor Street, Chicago, and will include visits to a number of Chicago hospitals. Instruction will be provided by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures.

Interested registrants will please write directly to the Department of Otolaryngology, College of Medicine of the University of Illinois at the Medical Center, P. O. Box 6998, Chicago, Illinois 60680.

Course in Gastroenterology Offered in Philadelphia in October

The annual postgraduate course in Gastroenterology of the American College of Gastroenterology will be given at the Bellevue Stratford in Philadelphia on October 27 to 29.

The subject matter to be covered, from the medical as well as the surgical viewpoint, will be essentially the diagnosis and treatment of gastrointestinal diseases and comprehensive discussions of diseases of the esophagus, stomach, pancreas, liver and gallbladder, small intestine and colon. A session on instrument technics will be held at the Albert Einstein Medical Center.

For enrollment and more information write American College of Gastroenterology, 33 W. 60th St., New York City 10023.

AMA Congress on Occupational Health Will Meet in September

The AMA Congress on Occupational Health will meet this year in Portland, Oregon on September 26 to 28. It will be in conjunction with the annual session of the Oregon Medical Association, as it was with the ISMA annual convention last year.

Details are obtainable from the AMA Council on Occupational Health, 535 N. Dearborn, Chicago 60610.

American Medical Writers Will Meet in New York City

The American Medical Writers' Association will hold its annual meeting at the Waldorf Astoria, New York City, September 29 through October 2, 1966.

Theme for the meeting will be "The Changing World of Medical Communication." For a copy of the program write A.M.W.A., 2000 'P' St., N. W., Washington, D. C. 20036.

Kidney Foundation of Illinois to Conduct Postgraduate Training Program

The Kidney Foundation of Illinois will conduct a professional medical symposium postgraduate training program at the Sheraton-Chicago Hotel on October 5, from 9 a.m. to 5 p.m.

Outstanding authorities in the prostate and renal field, including three speakers from England, one from France and one from Australia, will present papers. The cost of $15.00 per person will include luncheon. Details may be obtained by writing Mr. John Lane, Executive Director, 127 N. Dearborn St., Suite 701, Chicago 60602.

ISMA Members Invited to Indiana Society OF Radiologic Technologists Annual Meeting

The Indiana Society of Radiologic Technologists will hold its 27th annual meeting in Muncie at the Van Orman-Roberts Hotel, October 6 to 8. Members of ISMA are invited to attend.

Refresher courses, guest speakers, scientific papers and exhibits will constitute the scientific portion of the program. Details may be obtained by writing Joan M. Duncan, R.T., Ball Memorial Hospital, Muncie 47304.

American Academy of Pediatrics Sets Annual Meeting for October 22-27

ISMA members are invited to attend the annual meeting of the American Academy of Pediatrics, at the Palmer House Hotel, Chicago, October 22 to 27. The scientific program will include lectures, seminars, roundtable discussions and meeting of the pediatric subspecialties.

Several awards will be made during the meeting, including two E. Mead Johnson Awards for outstanding pediatric research. Registration fee for non-members out of school more than five years is $50; all others, including physicians of Armed Forces, $16. Program, housing forms and registration forms are procurable by writing the Academy at 1801 Hinman Ave., Evanston, Illinois 60204. ◄

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Deaths

L. Howard Allen, M.D.

Dr. L. Howard Allen, 67, Bedford obstetrician and gynecologist, died July 9 at Dunn Memorial Hospital.

Graduated from the I. U. School of Medicine in 1926, Dr. Allen started the practice of medicine with particular interest in obstetrics and gynecology in Bedford in 1928. In the span of his career, he delivered more than 8,000 babies. Dr. Allen was a veteran of both World Wars, a member of the Lawrence County Medical Society and served as vice-chairman of the ISMA Section on Obstetrics and Gynecology.

Dr. Allen was a founding fellow of the American College of Obstetrics and Gynecology, a fellow in the International College of Surgeons, and a charter member of the Indiana Obstetric and Gynecology Society.

Charles D. Benedict, M.D.

Dr. Charles D. Benedict, LaGrange physician and surgeon, died July 14 at LaGrange. He was 44.

An Army veteran of World War II, Dr. Benedict had practiced medicine in LaGrange for the past 10 years. He was a member of the LaGrange County Medical Society and had been president and secretary of that organization. Dr. Benedict was graduated from the I. U. School of Medicine in 1945.

O. T. Brazelton, M.D.

Dr. Osborne T. Brazelton, 79, former surgeon, physician and ex-mayor of Princeton, died August 3 in Seal Beach, Calif., at the age of 79.

Dr. and Mrs. Brazelton had been living in retirement in California for the past several years. Graduated from the Eclectic Medical College in 1912, Dr. Brazelton was a practicing physician and surgeon in Princeton for many years and served on the hospital board for several terms. He was mayor of Princeton in the early 1930's, a member of the Gibson County Medical Society, a Senior Member of ISMA and member of the ISMA 50-Year Club.

John A. Eisterhold, M.D.

Dr. John A. Eisterhold, 54, Evansville physician, died July 15 at his home.

Dr. Eisterhold began his medical practice in Evansville in 1939, after being graduated from the I. U. School of Medicine in 1937. He interned at St. Vincent's Hospital in Indianapolis and was a member of the Vanderburgh County Medical Society.

Bernard Grangier, M.D.

Dr. Bernard Grangier, Bartholomew county deputy coroner, died August 4 at the age of 37.

Graduated from the I.U. School of Medicine in 1962, Dr. Grangier practiced at Hope for about three years before moving to Columbus about two years ago. He was a member of the Bartholomew-Brown County Medical Society.

Frank H. Kelly, M.D.

Dr. Frank H. Kelly, 86, Argos, was struck by an auto and killed July 23 as he took his daily five-mile walk.

Dr. Kelly, graduated from the University of Illinois in 1913, is credited with being the developer of TAT-typing, the tattooing of a person's blood type on his body. The system was used extensively for American servicemen in World War II.

Dr. Kelly went to Argos in 1914 where he opened and operated a medical clinic until he retired in 1954. He served in World War I and was a member of the Marshall County Medical Society, the ISMA 50-Year Club and a Senior Member of ISMA.

I. H. Lawson, M.D.

Dr. I. H. Lawson, 81, Kendallville physician for 59 years and former city health officer, died July 17.

Dr. Lawson, graduated from Vanderbilt University in 1913, began his practice in 1914 as a medical doctor for United Fruit Steamship Co., sailing out of Boston. He went to Wolcottville in 1915, and moved his practice to Kendallville in 1920. Dr. Lawson was city health officer until he retired last year. He was a member of the Noble County Medical Society, a Senior Member and member of the ISMA 50-Year Club.

Michael Shellhouse, M.D.

Dr. Michael Shellhouse, 62, former president of the Lake County Medical Society, delegate to the ISMA and member of the ISMA Convention Arrangements Commission, died June 19 in Gary.

A Gary resident since 1911, Dr. Shellhouse was born in Poland. Graduated from the I.U. School of Medicine in 1934, he was chairman of the Medical Advisory Committee for Gary Public Schools at the time of his death. He also served as deputy coroner and as a member of the Gary Board of Health. A specialist in obstetrics and gynecology, Dr. Shellhouse was a member of the Indiana State Board of Medical Registration and Examination from 1950 to 1954 and was on the board of directors of the American Academy of General Practice.

S. Joseph Smith, M.D.

Dr. S. Joseph Smith, Vincennes physician and surgeon, died July 12 at the age of 50.

Dr. Smith, graduated from the I.U. School of Medicine in 1941, practiced in Vincennes for over 25 years. He was a member of the Knox County Medical Society.

James L. Walker, M.D.

Dr. James L. Walker, 78-year-old retired physician, died in the Wabash County Hospital August 3.

Member of the Wabash County Medical Society, Dr. Walker was graduated from the I.U. School of Medicine in 1913. His practice began in LaFontaine in 1914 and he was a veteran of World War I. He was a Senior Member and member of the ISMA 50-Year Club. ◄

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Association News

EXECUTIVE COMMITTEE

July 16, 1966

Present: G. O. Larson, M.D.; Kenneth O. Neumann, M.D.; Eugene S. Rifner, M.D.; E. T. Edwards, M.D.; Ottis N. Olvey, M.D.; Lester Hoyt, M.D.

Frank B. Ramsey, M.D., editor of *The Journal*; Ralph Hamill, attorney, and James A. Waggener, executive secretary.

Membership Report

Number of members as of December 31, 1965		4,394
1966 members as of June 30, 1966:		
Full dues paying	3,842	
Residents and interns	106	
Council remitted	51	
Senior	310	
Honorary	3	
Military	37	
Total 1966 members as of June 30, 1966		4,349
Number of members as of June 30, 1965		4,339
Gain over last year		10

Number of AMA members as of June 30, 1966		4,235
Total 1965 AMA members as of June 30, 1965		4,239
Loss over last year		4
1966 AMA members: Dues paying	3,730	
Exempt, but active	505	
		4,235
Number who have paid state dues but not AMA dues as of June 30, 1966		114

The membership report was reviewed and it was noted that 51 members had had their dues remitted by the Council. It was taken by consent to remind the Council that the Bylaws call for remission of dues only upon the basis of financial hardship.

Headquarters Office

The secretary asked permission to buy an additional storage shed at an approximate cost of $100.00. The request was approved on motion of Dr. Neumann, taken by consent.

The contract for employee coverage under Blue Cross and Blue Shield was reviewed and upon motion of Drs. Neumann and Rifner, the secretary was instructed to ask Blue Cross to submit to the association a summary of the utilization and the amount of funds placed in reserve for this particular group. The matter will be further studied upon receipt of this information.

Building Matters

The secretary called attention to the leak in the Council room and reviewed the various efforts to correct it and by consent it was agreed that he should endeavor to find someone to remedy this situation.

It was reported that the total amount due on all properties of the associaiton is $51,375.00.

Treasurer's Office

The treasurer's report was approved on motion of Drs. Neumann and Rifner.

Annual Convention, French Lick, October 10, 11, 12 and 13, 1966

The program outline for the annual meeting was reviewed.

The secretary reported on the correspondence with the Greene County, Missouri, Medical Society concerning the entertainment program, and upon recommendation of the president, taken by consent, the secretary was instructed to invite the Greene County Boys to supply the entertainment on Tuesday night, October 11.

It was noted that the outline of the program had omitted the president's reception and this is to be scheduled in the gardens at 6:00 p.m. and the dinner hour is to be changed to 7:15 p.m.

The speaker for Wednesday evening was discussed and the secretary, by consent, was instructed to invite Governor Roger D. Branigin as the speaker.

The proposal of the women physicians to have a program on Monday night open to the general membership was again reviewed and a letter was read from Dr. A. G. Popplewell stating the objections of the College of Chest Physicians to having a conflict with the Fireside Conferences. The secretary was therefore instructed to notify Dr. Betty Dukes of this objection and to inform her that if she desired to have a scientific program for the women physicians' group, it would be satisfactory but it could not be advertised as an open meeting.

The secretary asked the opinion of the committee concerning making the Lincoln Hotel the 1967 convention headquarters in Indianapolis, and consent was given to use the Lincoln rather than the Columbia Club, providing proper arrangements can be made.

Legislation

National:

The proposed bill to implement Title XIX was reviewed and in the discussion of this matter the motion was made by Drs. Rifner and Neumann that the entire issue of "reasonable charges" in the arrangements between the Blue Shield and the Welfare Department be referred to the Council.

Local:

The proposed bill on licensing of hearing aid dispensers and legislative goals of the Indiana Mental Health Association were reviewed for the information of the committee.

Editorial from The WFBM Stations concerning their advocating the adoption of the implied consent law for driver's license was reviewed for the information of the committee.

Medicare

Discussion was opened on the question of ethics and if they are enforceable, and upon motion of Drs. Rifner and Neumann, the committee was to recommend to the Council that the Council in turn instruct the Commission on Constitution and Bylaws to prepare conditions of membership, to be included in the Bylaws.

Information from the American Medical Association concerning its meetings with HEW on Regulation No. 5 were reviewed for the information of the committee.

Various bulletins distributed by the Indiana Hospital Association were reviewed for the information of the committee.

The Indiana Hospital Association report on its survey concerning hospital-based specialists was reviewed as was the survey made by the Indiana State Medical Association on this same subject.

The program for implementing Title XIX of the State of New York was also reviewed for the information of the committee.

A memorandum from the Department of HEW concerning reimbursement under Medicare for the services of hospital interns, residents, and supervising physicians was reviewed for the information of the committee.

A copy of a telegram to Blue Shield from Arthur Hess was read for the information of the committee.

A notation appearing in *The Blue Shield*, the newspaper of the National Association of Blue Shield Plans, concerning the plans of the Massachusetts Medical Society and Massachusetts Blue Shield to consolidate Medicare payments was reviewed for the information of the committee.

A letter from the Tippecanoe County Medical Society was called to the attention of the committee.

A letter from G. O. Larson, M.D., concerning a form which had been distributed to the physicians of LaPorte county authorizing their hospitals to act as a billing and collecting agent was read and upon motion of Drs. Neumann and Rifner, the committee advised the secretary to answer that, in the absence of a legal opinion to the contrary, it should be recommended that the physicians of LaPorte county should not sign such an agreement.

The Blue Shield forms to be used in the Medicare program and letters from Drs. T. C. Person and Jay S. Reese were read for the information of the committee.

The committee then discussed the directive which had been distributed by Blue Shield calling attention to the fact that Blue Shield had entered into a contract with the State Department of Public Wel-

fare for paying all supplemental benefits under Part B, Title XVIII of PL 89-97, in which it was pointed out that physicians would have to accept assignments in caring for welfare cases under this program. After a discussion, it was to be recommended to the Council that they take note of this contract and that the statement is in conflict with the policy of the Indiana State Medical Association, and furthermore, it is believed that the contract under the present terminology is an illegal contract. This action was taken by consent.

The attorney reported on the action taken in the Wabash County case and inasmuch as the physician in the case had been successful in obtaining his arrangement without the necessity of going to trial and had dismissed the case, it left the question without legal precedence.

Upon motion of Drs. Rifner and Hoyt, it was voted that the Executive Committee should recommend to the Council that they instruct the legal counsel to proceed with litigation, if necessary, as previously outlined by the Council; that first an attempt be made to resolve the question around the conference table and this failing, that steps be taken through appropriate litigation to resolve the issue.

In further discussion of the Blue Shield and this matter, the following actions were taken:

Upon motion of Drs. Rifner and Neumann, it was to be recommended to the Council that they in turn reprimand the Blue Shield Board concerning the contract and that the contract be disapproved by the Council, and that the contract be renegotiated to provide that Blue Shield only has the facilities and the means for providing reimbursement, and to delete the provision that they can furnish the services.

On motion of Drs. Edwards and Rifner, it is to be recommended to the Council that in the opinion of the Executive Committee, the Council should express its strong disapproval of the manner in which this contract was drawn and its content, and approved by the Executive Committee of Blue Shield, especially when it is in conflict with the stated policy of the Indiana State Medical Association.

In an additional motion by Drs. Edwards and Rifner, the Executive Committee voted further to recommend to the Council that the Council remind Blue Shield that the Indiana State Medical Association and the American Medical Association have both recommended that assignments not be taken by physicians in this state and nation.

Organization Matters

Resignation of Dr. Francis Land as a delegate to the AMA was received and accepted. Dr. Land is moving from Indiana to Washington, D.C., where he has accepted a position with the Department of HEW.

A report on the recent meeting of the Marion County Medical Society with chiefs of staffs of the various hospitals was given for the information of the committee.

A letter from Dr. Culbertson was reviewed for the information of the committee.

A letter from Dr. Grant Metcalfe concerning activities of the selection committee for replacement for Dr. S. T. Ginsberg was reviewed and by consent it was agreed to recommend Dr. Glen Ward Lee of Richmond as a member of this committee.

The announcement of the dinner honoring Dr. Ginsberg, retiring Commissioner of the Department of Mental Mealth, was called to the attention of the committee.

The president discussed the appointment of hosts for convention guests and it was agreed that this would be handled at the Council meeting.

Renewal of membership in the Indiana Conference on Social Welfare in the sum of $15.00 was approved on motion of Drs. Neumann and Edwards.

The publications, *Guidelines*, for regional medical programs, was called to the attention of the committee for its information.

A letter from Dr. H. G. Becker, chairman of the Commission on Public Information, concerning the plans of the commission to make three public relations awards at the convention was reviewed. On motion of Dr. Edwards, taken by consent, Dr. Becker was to be requested to supply the committee with information on the basis on which these awards are to be made.

Future Meetings

Upon motion of Drs. Neumann and Rifner, the Executive Committee and staff of the Indiana State Medical Association were authorized to attend the AMA Public Relations Institute in Chicago, August 25-26, 1966.

Notice of the AMA Rehabilitation Conference, September 8 and 9, 1966, was reviewed. Upon motion of Dr. Rifner, taken by consent, the association will not send an official representative to this meeting but the notice and correspondence is to be sent to Dr. Herman Wing, saying that he individually might like to attend this meeting.

Third National Conference on Medical Quackery, Chicago, October 7 and 8, 1966. By consent it was agreed to ask Dr. Otis Bowen or Dr. Dwight Schuster if they would like to attend this meeting.

AMA Symposium on Immunization, Atlanta, October 17, 1966. It was decided that no representative would be sent to this meeting.

It also was decided that no representative would be sent to the meeting of the Congress on Occupational Health at Portland, Oregon, on September 26-30, 1966.

There being no further business the Executive Committee adjourned, to meet again at 6:00 p.m., at the Drake Hotel, Chicago, Wednesday evening, August 24, 1966. ◄

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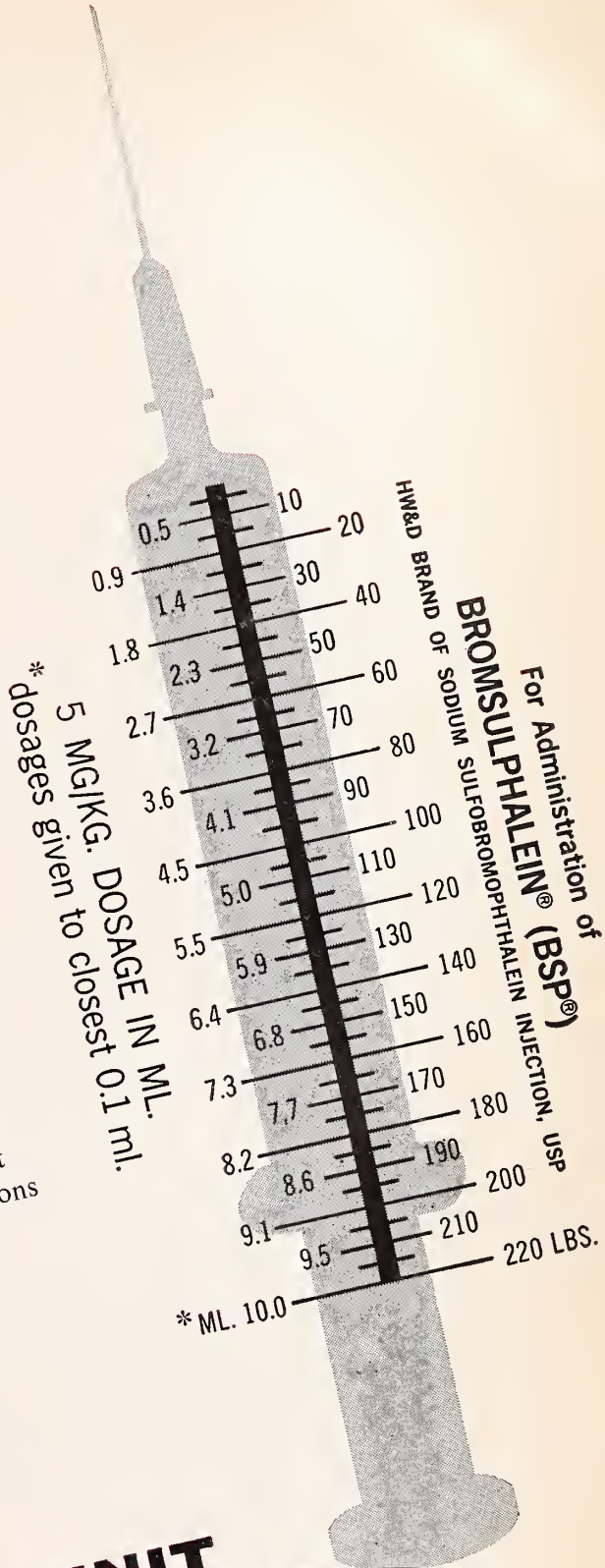

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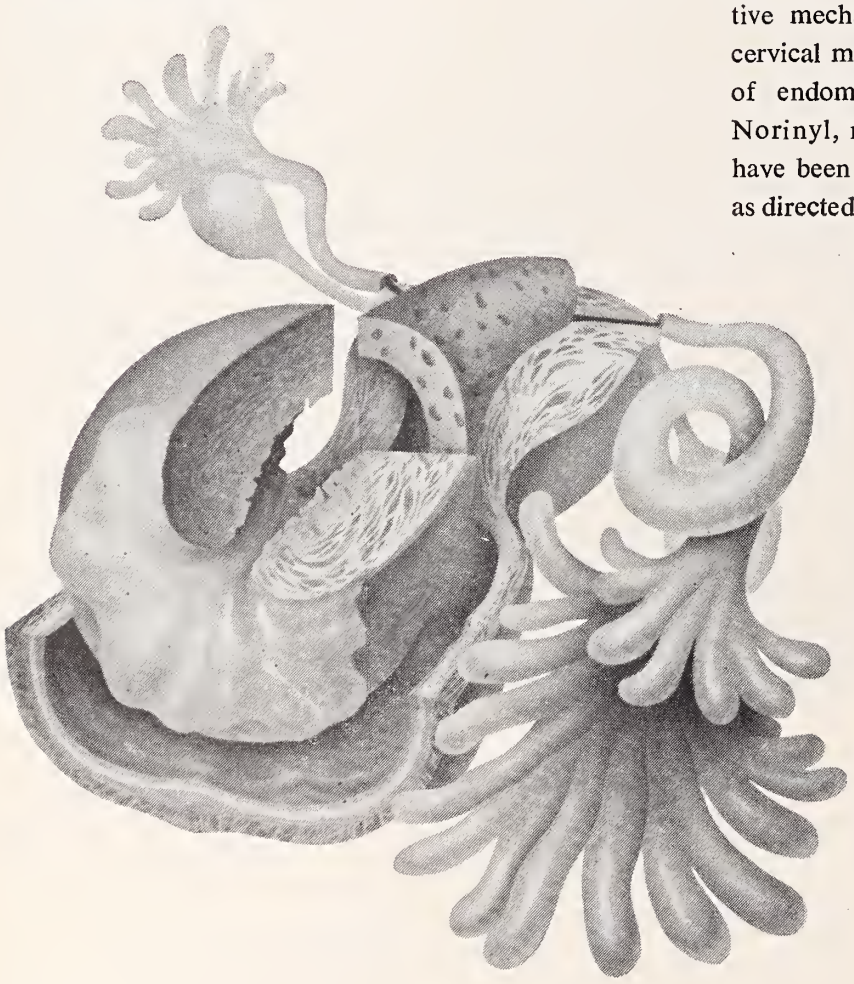

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References: 1. Council on Drugs. JAMA 187:664 (Feb. 29) 1964. 2. Brvans, F. E.: Canad Med Ass J 92:287 (Feb. 6) 1965. 3. Goldzieher, J. W.: Med Clin N Amer 48:529 (Mar.) 1964. 4. Cohen, M. R.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965. 5. Hammond, D. O.: Ibid. 6. Rice-Wray, E., Goldzieher, J. W., and Aranda-Rosell, A.: Fertil Steril 14:402 (Jul.-Aug.) 1963. 7. Goldzieher, J. W., Moses, L. E., and Ellis, L. T.: JAMA 180:359 (May 5) 1962. 8. Kempers, R. D.: GP 29:88 (Jan.) 1964. 9. Tyler, E. T.: JAMA 187:562 (Feb. 22) 1964. 10. Rudel, H. W., Martinez-Manautou, J., and Maqueo-Topete, M.: Fertil Steril 16:158 (Mar.-Apr.) 1965. 11. Flowers, C. E., Jr.: N Carolina Med J 25:139 (Apr.) 1964. 12. Goldzieher, J. W.: Appl Ther 6:503 (June) 1964. 13. The Control of Fertility. Report adopted by the Committee on Human Reproduction of the American Medical Association. JAMA 194:462 (Oct. 25) 1965. 14. Flowers, C. E., Jr.: JAMA 188:1115 (June 29) 1964. 15. Merritt, R. I.: Appl Ther 6:427 (May) 1964. 16. Newland, D. O.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965.

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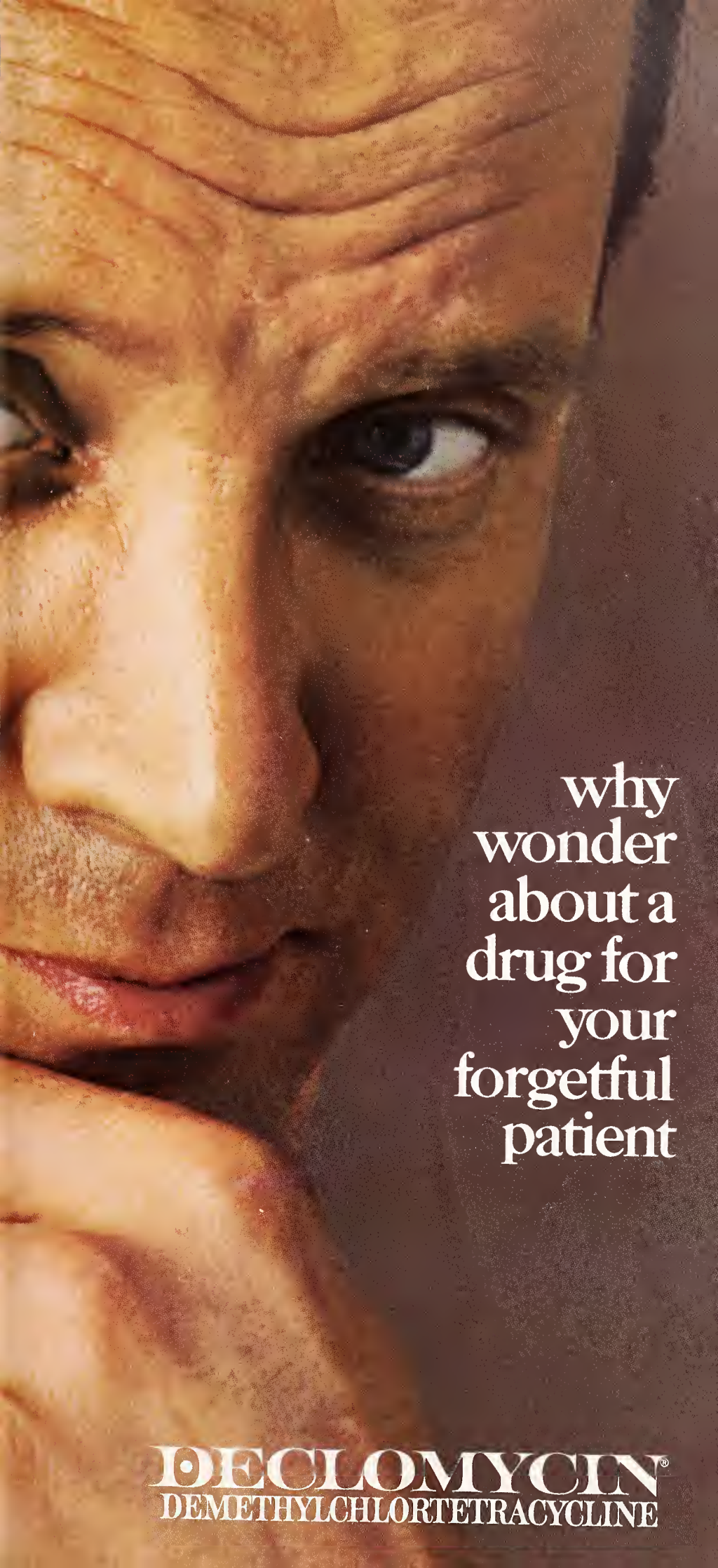
4.	Harold W. Richmond, Columbus	David L. Adler, Columbus	Columbus, 1967
5.	John Ellett, Jr., Coatesville	Richard Veach, Bainbridge	Greencastle, May 17, 1967
6.	J. J. Farrell, Jr., Greenfield	Stephen D. Smith, Knightstown	
7.	Jay Reese, Martinsville	James H. Gosman, Indianapolis	
8.	Donald E. Spahr, Portland	Joseph F. Vormohr, Portland	Portland, June 7, 1967
9.	Harry T. Stout, Frankfort	Earl K. Williams, Frankfort	May 18, 1967
10.	Leslie Bombar, Munster	Louis Kudele, Whiting	
11.	Joseph Bean, Logansport	Everett C. Taylor, Upland	Logansport, Sept. 13, 1967
12.	Warren L. Niccum, Columbia City	Kenneth F. Isenogle, Fort Wayne	Fort Wayne, May 17, 1967
13.	James W. Hurley, Elkhart	Cecil R. Burket, Bremen	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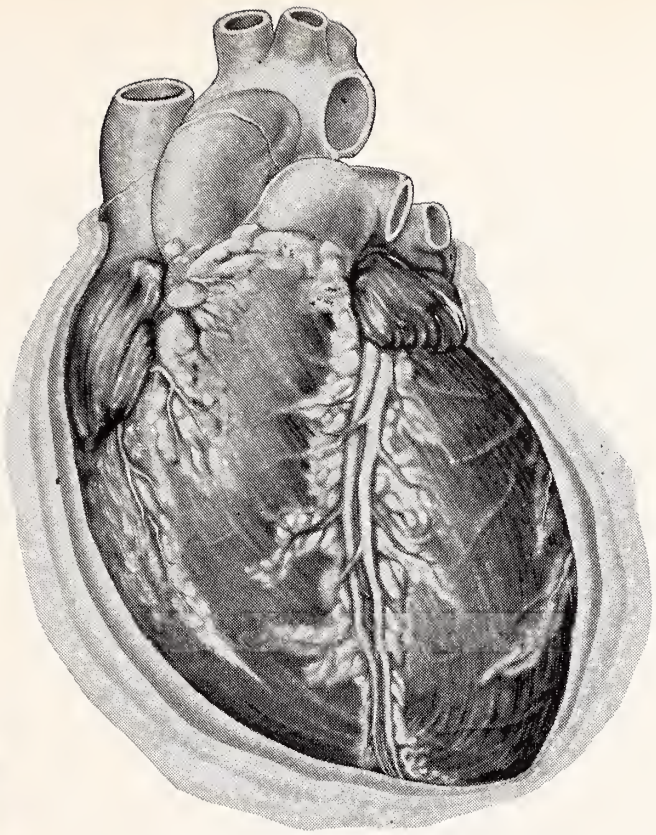

Aids in long term management of Paroxysmal Tachycardia

FOR REPLACEMENT OF MINERAL DEPLETION (potassium and magnesium) IN THE MYOCARDIUM

AIDS POST-SUPPORTIVE MANAGEMENT OF CARDIAC INFARCTION

Paul Dudley White, M.D.: Heart Disease, 4th Ed., "It is to be remembered that toxic doses of digitalis may themselves cause paroxysmal tachycardia, especially of ventricular type. Potassium salts have also been recommended for obstinate tachycardia, as in the case of premature beats; Stempien and Katz (1942), for example, have advised giving 1 or 2 gm of potassium chloride or acetate every two to four hours to supplement or reinforce the action of quinidine." (page 888)

Kleiner and Orten: Biochemistry, 6th Ed., "Potassium is necessary for nerve activity. Nerve fibers are exceptionally rich in this element. When the nerve is stimulated, potassium diffuses into the surrounding fluid rapidly, and during rest diffuses back." (page 605) "It cannot be stated that in any of these conditions the lack of Vitamin C is a primary causative factor, but it may be significant that the vitamin blood level is found to be reduced in many pathological states." (page 352)

Richard H. Follis, Jr., M.D.: Deficiency Disease, "Myocardial effects of potassium deficiency have been described in rats, mice, rabbits, dogs and calves. The tissues which appear to suffer most are myocardium, striated muscle and kidneys." (page 25) "McCollum has called attention to the appearance of tachycardia as acute magnesium deficiency develops; electrocardiograph studies in rats reveal sinoaricular block." (page 38)

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Each four tablets supply:

Potassium	64 mg
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Ascorbic Acid	1000 mg

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Orally, one tablet 3 or 4 times per day.

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Corcoran, A. C.: The choice of drugs in the treatment of hypertension. In: Drugs of Choice 1966-67, W. Modell, Ed., St. Louis, C. V. Mosby Company, 1966, p. 417.

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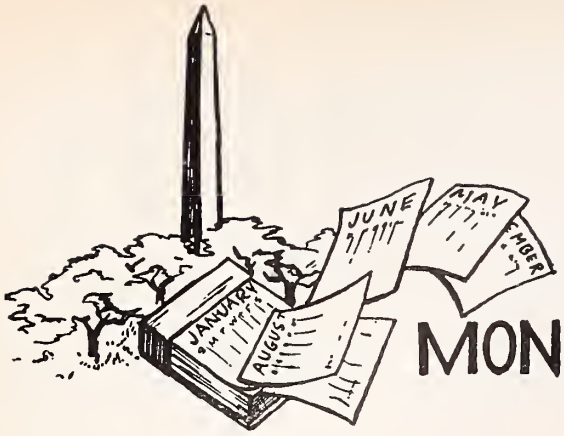

This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

MONTH IN WASHINGTON

WASHINGTON, D.C.—The Advisory Committee on Obstetrics and Gynecology to the Food and Drug Administration reported that in a nine-month study it could find "no adequate scientific data" that birth control pills are "unsafe for human use."

BUT THE COMMITTEE said that there are "possible theoretic risks" in the use of oral contraceptives. For this reason, the committee recommended further, extensive tests to learn more about possible side-effects and to improve surveillance of the drugs.

THE FDA accepted this proposal and other committee recommendations, including discontinuance of time limitations on use of oral contraceptives.

FDA COMMISSIONER Dr. James Goddard said the agency would like to start studies on up to 50,000 women next year and eventually on as many as 500,000 women. The biggest drug studies thus far have involved only 20,000 or 30,000 women.

"THE COMMITTEE FINDS no adequate scientific data, at this time, proving these compounds unsafe for human use. It has nevertheless taken full cognizance of certain very infrequent but serious side-effects and of possible theoretic risks suggested by animal experimental data and by some of the metabolic changes in human beings," the committee concluded.

"IN THE FINAL ANALYSIS, each physician must evaluate the advantages and the risks of this method of contraception in comparison with other available methods or with no contraception at all. He can do this wisely only when there is presented to him dispassionate scientific knowledge of the available data."

THE FDA SAID it would lift shortly its recommended limits on use of the pill. The agency has required that manufacturers state on their labels and advise physicians that the oral contraceptives should be used by individuals for no more than four years because of concern about the unknown long-term effect of the medications. FDA officials and the advisory committee agreed that there isn't any sound scientific rationale for the restriction, because of the current lack of data that would indicate that the pills are dangerous.

OTHER STEPS that FDA officials said would be taken as a result of the report include imposition of uniform labeling requirements on all types

Continued

Breast-feeding and the "modern mother"

Despite a mild resurgence of interest in the importance of breast-feeding a few years ago, many women today do not choose to nurse their young. This is for a variety of reasons—social, economic, cultural and sometimes medical. In such cases the physician's task is to find the most suitable means of preventing lactation and easing the pain of breast engorgement.

The means of therapy

The value of hormone therapy for this indication is of course well established. Both androgen and estrogen are known to inhibit the production and secretion of the lactogenic hormone by the anterior pituitary. As estrogen levels decline sharply at parturition, lactogenesis is established. When androgen and estrogen are administered to the patient before the release of the lactogenic hormone lactation and breast engorgement are usually prevented.

The time of therapy

The time of administration of this combined medication is crucial; it must be given early enough to suppress the pituitary prolactin and last long enough to permit physiologic readjustment during the puerperium. Excellent results are most often seen when therapy is administered before the onset of the second stage of labor.

However, factors other than effectiveness must also be considered. The agent selected should not interfere in any way with parturition, subsequent uterine involution and the restoration of normal ovarian cyclic function. Furthermore, it should not cause rebound breast engorgement or other manifestations of hormonal imbalance.

A balanced formulation

Providing single-dose therapy for the prevention of lactation and breast engorgement, Deladumone OB is a potent androgen-estrogen combination with a prolonged action. The optimal balance of androgenic and estrogenic hormones achieved in this preparation minimizes the disadvantages inherent in single hormone therapy, such as rebound breast engorgement. Involution of the uterus and resumption of menstrual cycles are not affected.

As reported in a recent published study (Roser, D. M.: Obstet. & Gynec. *27*:73, 1966), Deladumone OB provided good suppression of breast engorgement in 95.3% and suppression of lactation in 81.1% of 86 obstetrical patients. These results are in general agreement with those of many earlier investigations; in several studies this injectable androgen-estrogen combination proved to be superior to oral medication.

Dosage:

As a single injection of 2 cc. before the onset of the second stage of labor.

Contraindications:

Established or suspected mammary cancer or genital malignancy.

Precautions and Side Effects:

Certain patients may be unusually responsive to either estrogenic or androgenic therapy. In such individuals virilization, uterine bleeding or mastodynia may occur.

Supply:

Deladumone OB, providing 180 mg. testosterone enanthate and 8 mg. estradiol valerate per cc., is available in 2 cc. Unimatic® disposable syringes and in 2 cc. vials. Both preparations are dissolved in sesame oil, with 2% benzyl alcohol as a preservative. *Before use, consult product literature for full prescribing information.*

Deladumone® OB

Squibb Testosterone Enanthate (180 mg./cc.) and Estradiol Valerate (8 mg./cc.)

Single-dose injection for lactation inhibition

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of oral contraceptives, elimination of product-by-product variations that have confused physicians and allowed companies to make different promotional claims, and restrictions of the use of the products for some medical purposes, such as prevention of abortion and treating lack of menstruation or painful menstruation, as well as conception control.

"THE ORAL contraceptives present society with problems unique in the history of human therapeutics," the committee said. "Never will so many people have taken such potent drugs voluntarily over such a protracted period for an objective other than for the control of disease. These compounds, furthermore, furnish almost completely effective contraception, for the first time available to the medically indigent, as well as the socially privileged. These factors render the usual standards for safety and surveillance inadequate. Their necessary revision must be carefully planned and tested, lest the health and social benefits derived from these contraceptives be seriously reduced.

"PROBABLY no substance, even common table salt, and certainly no effective drug can be taken over a long period of time without some risk, albeit minimal. There will always be a sensitive individual who may react adversely to any drug, and the oral contraceptives cannot be made free of such adverse potentials, which must be recognized and kept under continual surveillance. The potential dangers must also be carefully balanced against the health and social benefits that effective contraceptives provide for the individual woman and society.

"THE ORAL contraceptives currently in use are probably not those that will be employed 10 or even five years hence. Drugs with even less potentially adverse effect, utilizable in smaller dosage, will undoubtedly be developed through continuing research."

BRAND VS. GENERIC DRUGS

THE AMERICAN MEDICAL Association opposed legislation that would make prescribing drugs by generic name mandatory under the federal program of medical care for dependents of military personnel.

THE AMA expressed its opposition in a letter to a joint House-Senate committee that was considering such legislation. The letter said:

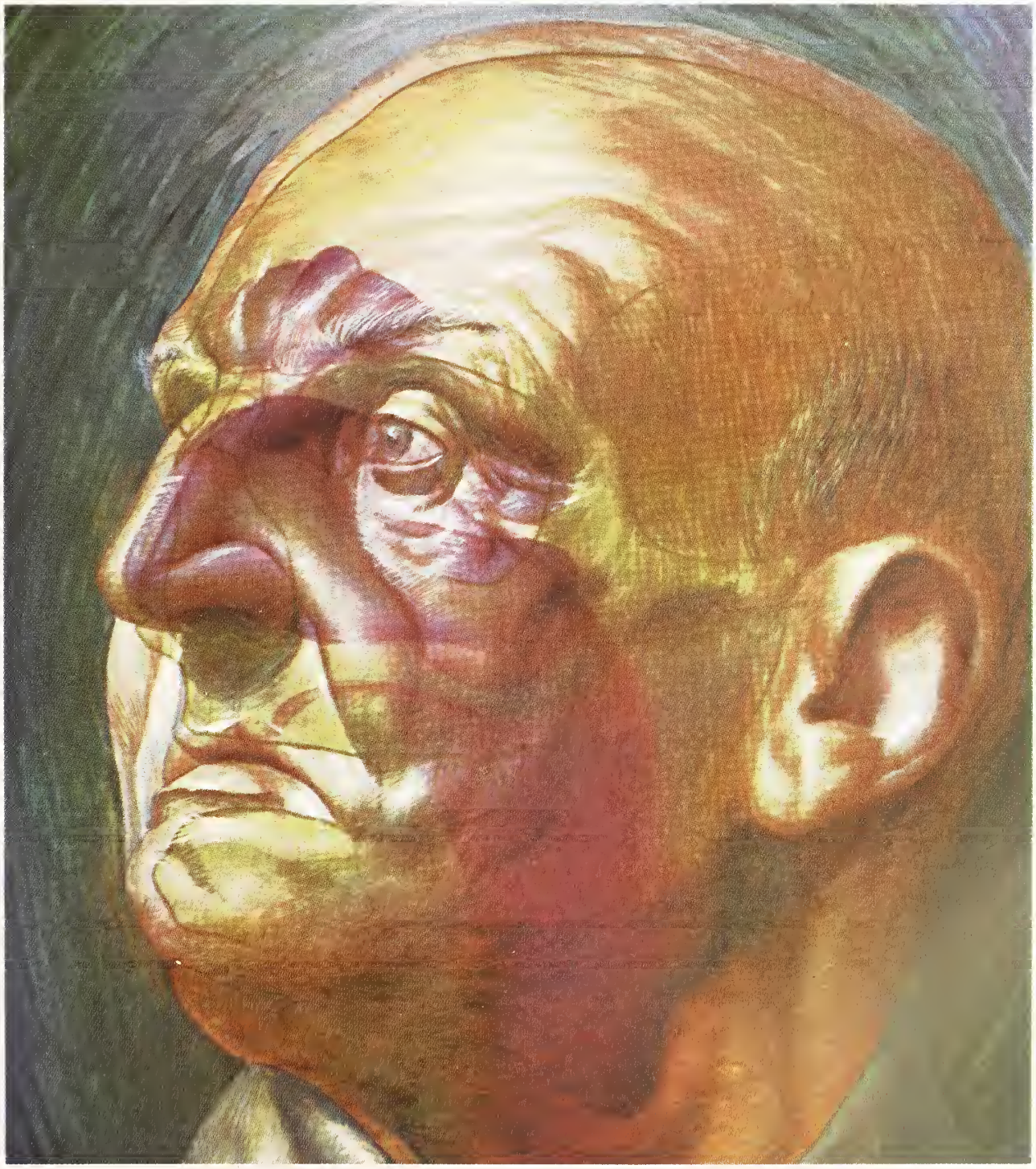
"THE GENERIC NAME refers to the active chemical ingredient of the drug and not to the finished product which is supplied to the patient. In order that it may be dispensed, the trade name manufacturer, by way of a specific formulation, processes the drug to its final form. For

Continued

fall 1966

DORSEY Season

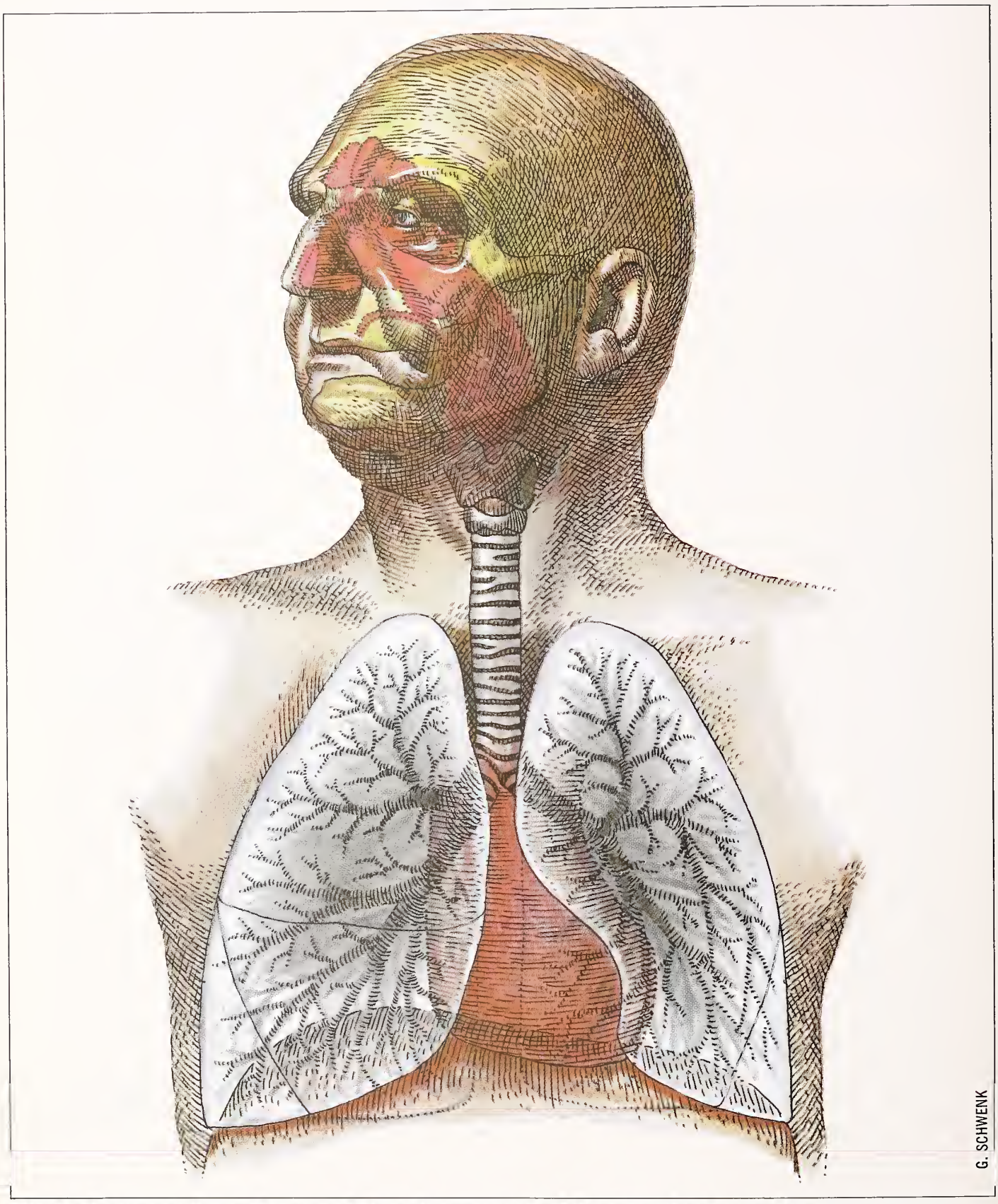
A journal within a journal published quarterly in the interests of better medicine by Dorsey Laboratories, a division of The Wander Company, Lincoln, Nebraska. Address communications to Raymond C. Pogge, M.D., Director of Medicine.



this issue: the common cold and the aging patient

the common cold and the aging patient

Louis J. Vorhaus, II, M.D., F.A.C.P.



Effects of aging on the anatomic and physiologic aspects of the respiratory apparatus.

The chest becomes more fixed, less mobile and less elastic as the bronchial walls and thoracic ligaments lose elasticity. The diaphragm and intercostal muscles atrophy and weaken. The lungs become smaller, flabbier and weigh less, decreasing vital and total lung capacity, increasing residual volume and the alveolar dead space.

Sir William Osler described pneumonia as the welcome friend of the aged patient, because the patient with pneumonia usually died quietly. But today, the well-informed physician is an even better friend of the aging patient, since it is better to live than to die, no matter how quietly.

One of the first avenues of approach in the control of the hazards of respiratory disease in the aging patient is prompt and proper attention to the common cold or upper respiratory infection. The common cold may be the first step in the relatively short path to lower respiratory infection, broncho-pneumonia and death. This train of events occurs frequently among older persons. Indeed, pneumonia is one of the most common causes of their admission to hospitals and ranks high on the list of geriatric killers. Colds are more debilitating in elderly people and the aged are more likely candidates for secondary infections such as sinusitis and bronchitis. These infections, in turn, are more prone to lead to bronchopneumonia, because of lowered resistance and anatomic and physiologic changes in the lungs of the elderly.

What is different about the respiratory tree of an aged person and that of an otherwise healthy younger adult? Aging certainly takes its toll on all parts of the body, affecting both anatomic and physiologic aspects of the respiratory apparatus. These changes are in part due to the wear and tear that occurs over the years; the repeated bouts of respiratory infection, long exposure to atmospheric pollutants, to occupational inhalants, smoking, malnutrition, obesity, inactivity and the development of other diseases which may affect the lungs.

With the passage of years, the lungs change. They become scarred and emphysematous and lose their compliance. The whole chest becomes more fixed, less mobile and less elastic.

The anatomic changes that occur in aging render the lungs less efficient. Tests of pulmonary function in senescence show a deterioration characterized by a decrease in vital capacity and total lung capacity, an increase in residual volume and alveolar dead space. Maximum breathing capacity is reduced and uniformity of ventilation deteriorates. These problems are often aggravated by the obstructed breathing, fever and secondary infection associated with the common cold, placing an additional stress on the entire cardiopulmonary reserve.

In addition, the efficiency of a cough is below par in older persons even though they are in good health. This is partly due to the decreased respiratory excursions and distensibility of the chest wall, and partly from loss of elasticity of bronchial walls which tend to make them collapse in a cough.

The elderly patient's resistance to infection is often reduced. Nutritional deficiencies are more common in aged people. There is some evidence to indicate that their capacity to respond to stress is less efficient. Finally, there is often relatively meager symptomatic response to acute disease. The absence of obvious or dramatic clinical signs and symptoms of severe illness is particularly dangerous because, coming as it

(concluded on following page)

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Side effects: Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. Precautions: The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

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does in a person whose defenses are weakened both locally and systemically, pulmonary disease may progress rapidly to irreversible stages before medical attention is sought. Respiratory infection is especially hazardous because the aged patient responds badly to hypoxia. Not only is his response to oxygen lack impaired, but the work of breathing, due to decreased compliance of the lung and increased stiffness of the thorax, is markedly augmented.
Many patients late in life are in a precarious and delicate cardiopulmonary balance which is easily decompensated from relatively minor insults such as colds and upper respiratory infections.

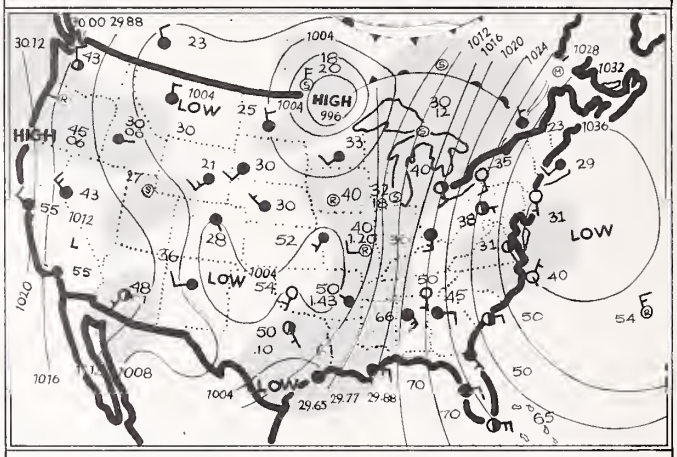
For all of these reasons, geriatricians long have stressed the importance of preventing respiratory insults. Today we have better ways of treating respiratory infection, improved techniques for clearing the lungs and bronchial tubes of secretions and better understanding of ways of improving ventilation. We possess a broader spectrum of antimicrobial agents including newer ones to deal with previously resistant organisms. Even so, the death rate from pneumonia is high in older people, and it is preferable to avoid the disease than to treat it. To do so, attention must be paid to the general maintenance of good health and all that implies, as well as to the prevention, elimination and treatment of associated conditions that predispose to or cause pneumonia such as chronic upper or lower respiratory infection, respiratory allergy, chronic sinusitis and exposure to inspired irritants.

Colds and other minor respiratory infections, which favor the development of broncho-pneumonia, should be treated vigorously and promptly, particularly those patients whose aging process has been accompanied by the development of chronic pulmonary disease. Upper respiratory passages should be cleared with decongestants. Sinuses should be drained adequately. And, when indicated, appropriate antimicrobial therapy should be instituted before serious infection of the lower respiratory tree supervenes.

In decades past it was understandable that physicians welcomed pneumonia for the aged patients because it offered them a quiet and peaceful demise. Today we recognize that in many cases, peaceful as it may have been, such deaths were often avoidable. With the current knowledge and understanding of the problems that respiratory infections impose on aging people, vigilant medical attention can often restore them to a vigorous, rewarding and productive life so that the many opportunities that exist today for people to enjoy their golden years are realized and not stolen by untimely death.

References 1. Steiglitz, Edward J., Geriatric Medicine, Medical Care of Later Maturity, 3rd edition, J. B. Lippincott Co., Philadelphia, 1954. 2. Norman, J. R., Schweppe, I. H., Salazar, E. and Knowles, J. H., Lung Volumes and Aging, Journal of the American Geriatrics Society, 12, pp. 38-47, January 1964. 3. Penman, Robert W. B., Hypoxia and Respiratory Failure, Geriatrics, 18, 807-814, November 1963. 4. Middleton, William S., Some Medical Dissections on Aging, Geriatrics, 18, 168-73, March 1963. 5. Cole, M. B. and Roberts, F. E., Clinico-Pathologic Study of Emphysema, Journal American Geriatrics Society, 12: 415-419, May 1964. 6. Horton, Glenn, Testing of Pulmonary Function, Geriatrics, 17:73-81, February 1962. 7. Banyai, Andrew L., Cough and its Management in Elderly Patients, Geriatrics, 14:621-630, October 1959. 8. Howell, T. H. and Piggot, A. P., Morbid Anatomy of Old Age, Geriatrics, 8:267-72, March 1953.

Weather Forecast Throughout the Nation



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Dextromethorphan hydrobromide ..... 30 mg.
Terpin hydrate ..... 180 mg.
Acetaminophen ..... 325 mg.

Side effects: Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. Precautions: Patient should not drive a car or operate dangerous machinery if drowsiness occurs. Except under professional care, do not give to patients under 12 yrs. or those who have persistent cough, high fever, heart or thyroid disease, hypertension or diabetes or use for more than 10 days.

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when congestion is complicated by sulfa-susceptible bacterial invaders in the upper respiratory tract...

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Each tablet contains: Triaminic® 25 mg. (phenylpropanolamine hydrochloride 12.5 mg., pheniramine maleate 6.25 mg., pyrilamine maleate 6.25 mg.); Trisulfapyrimidines, U.S.P. 0.5 Gm. (sulfadiazine 0.167 Gm., sulfamerazine 0.167 Gm., sulfamethazine 0.167 Gm.)

PHARMACOLOGY: Triaminic decongests and promotes drainage of nasal and paranasal passages, and prevents any further histamine-induced damage; the triple sulfonamides inhibit susceptible bacterial invaders. INDICATIONS: For congestion and infection of the upper respiratory tract caused by sulfa-susceptible organisms. DOSAGE: Adults: 2 to 4 tablets initially, followed by 2 tablets every 6 hours. Medication should be continued until patient has been afebrile for 3 days. ADVANTAGES: The advantages of Trisulfaminic in upper respiratory infections are: freedom from narcotics or alcohol; therapeutic reliability; safety; economy; ease of administration; freedom from potential sensitization to broad-spectrum antibiotics which may be reserved for lower respiratory or other infections caused by susceptible organisms. CONTRAINDICATIONS: Contraindicated in sulfonamide and antihistamine sensitivity, impaired renal function, pregnancy approaching term, and in premature infants and newborn infants during the first month of life. Do not use in patients with glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal or bladder neck obstruction. WARNING: Use only after careful evaluation in patients with liver or renal damage, urinary obstruction, or blood dyscrasias. Deaths have been reported from hypersensitivity reactions with administration of sulfonamides. In intermittent or prolonged therapy, blood counts and liver and kidney function tests should be performed periodically. Sulfonamide therapy may potentiate the hypoglycemic action of sulfonylureas. PRECAUTIONS: Use with caution in patients with histories of significant allergy or asthma. Assure an adequate fluid intake. Because the antihistamines may cause drowsiness of varying degree, warn patients about activities requiring alertness such as driving a car or operating dangerous machinery. Use with caution in the presence of hypertension, hyperthyroidism, cardiovascular disease and diabetes. ADVERSE REACTIONS: As in all sulfonamide therapy, the following reactions may occur: headache, nausea, vomiting, diarrhea, icterus, hepatitis, pancreatitis, urticaria, rash, fever, cyanosis, hematuria, crystalluria, proteinuria, blood dyscrasias, petechiae, purpura, neuropathy and injection of the conjunctiva and sclera. If one or more of these reactions occur, the drug should be discontinued. With antihistaminic therapy there have been reports of sedation varying from mild drowsiness to deep sleep, dizziness, lassitude, inability to concentrate, fatigue, incoordination, tinnitus, blurred vision, diplopia, euphoria, nervousness, insomnia, tremors, palpitation, hypotension, headache, chest tightness, urinary frequency, dysuria, tingling of the hands, dryness of the mouth, throat, and nose, gastrointestinal disturbances such as epigastric distress, anorexia, nausea, vomiting, constipation and diarrhea and very rarely, leukopenia and agranulocytosis. Adverse reactions reported with the use of sympathomimetic amines include anxiety, tension, restlessness, nervousness, tremor, weakness, insomnia, headache, palpitation, tachycardia, angina, elevation of blood pressure, sweating, mydriasis, anorexia, nausea, vomiting, dizziness, constipation, and dysuria due to vesicle sphincter spasm. PACKAGE INFORMATION: Trisulfaminic Tablets: Supplied in bottles of 100 tablets. CAUTION: Federal law prohibits dispensing without prescription.

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example, included in a manufacturer's preparation of a tablet form of a drug may be a number of variables such as the crystalline size, the nature of t he excipients, the coloring agents and flavors, the tableting pressures, coating films and the orientation within the tablet.

"SINCE the finished product, depending on who has manufactured it, may emerge in any one of several forms, it becomes apparent that a generic-named drug supplied by one manufacturer may differ to a significant degree from the same generic-named drug supplied by another manufacturer. Yet, if the physician is compelled to prescribe by generic name, he would have no control as to which drug is used by the pharmacist in filling the prescription.

"THE COATING, the disintegration time, the solubility, the choice of vehicle or base, these and other factors may be extremely important to the physician who chooses a drug for his patient. He must have the opportunity to specify that drug containing the variables he has found suitable to the treatment of his patient. Further, where his patient is receiving the same medication over a period of time, successive refills of the same prescription with products of different manufacturers could lead to variations in therapeutic response which may mislead him.

"IT HAS BEEN SUGGESTED that generic prescribing would result in substantial savings. This may be true in some instances, but certainly not in all. Generic prescribing would allow the pharmacist to furnish the patient with that manufactured drug he, the pharmacist, has chosen. It may or may not be less expensive. In any event, it is the pharmacist who sets the final price.

"THE ARGUMENT of generic prescribing versus trade name prescribing has been heard at scientific gatherings, seen in scientific publications, and debated in the committees of Congress. But as to one element of the discussion, almost all physicians agree. For a variety of sound medical reasons, the choice of whether to prescribe generically or by brand name should be that of the treating physician. No law should be passed which may compel him to use in every case, a generic or non-proprietary drug. Such a law would not be in the best interest of his patient." ◄

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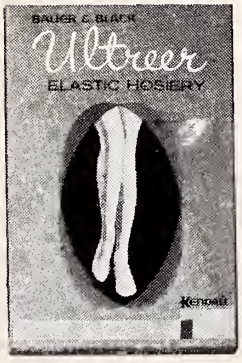
Ultreer. What a stocking.



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When functional fatigue complicates convalescence, Alertonic can help...

Pleasant-tasting Alertonic is pipradrol hydrochloride—an effective cerebral stimulant whose gentle analeptic action helps counteract the apathy and inertia that can often delay convalescence—together with an excellent vitamin and mineral formula, in a satisfying 15% alcohol vehicle.

Nothing fosters confidence and a sense of well-being better than your own personal warmth, understanding and encouragement together with Alertonic to help insure prompt response.

Adequate dosage is important: Prescribe Alertonic—one tablespoonful t.i.d., 30 minutes before meals...tastes best chilled.

And for your patient's sake, prescribe Alertonic in the convenient, economical one-pint bottle.

Alertonic®

Available Only On Prescription

Each 45 cc. (3 tablespoonfuls) contains: alcohol, 15%; pipradrol hydrochloride, 2 mg.; thiamine hydrochloride (vitamin B_1) (10 MDR*), 10 mg.; riboflavin (vitamin B_2) (4 MDR), 5 mg.; pyridoxine hydrochloride (vitamin B_6), 1 mg.; niacinamide (5 MDR), 50 mg.; choline,† 100 mg.; inositol,† 100 mg.; calcium glycerophosphate, 100 mg. (supplies 2% MDR for calcium and for phosphorus) and 1 mg. each of the following: cobalt (as chloride), manganese (as sulfate), magnesium (as acetate), zinc (as acetate), and molybdenum (as ammonium molybdate).

*Multiple of adult Minimum Daily Requirement supplied.
†The need for these substances in human nutrition has not been established.

Indications: 1. Functional fatigue such as that often associated with: a depressing life experience or stressful time of life; advancing years; convalescence; limited activity or confinement. 2. Poor appetite and vitamin-mineral deficiency as they occur in: patients having faulty eating habits; geriatric patients who are losing interest in food; patients convalescing from debilitating illness or surgery.

Dosage: Adults, 1 tablespoonful; children (over 15 years old), 1 to 2 teaspoonfuls; children (4 to 15 years old), 1 teaspoonful. To be taken three times daily 30 minutes before meals.

Contraindications: As with other drugs with CNS stimulating action, Alertonic is contraindicated in hyperactive, agitated or severely anxious patients and in chorea or obsessive compulsive states.

Side effects: Reports of overstimulation have been rare. Patients who are known to be unduly sensitive to the effects of stimulant drugs should be observed carefully in the initial stages of treatment.

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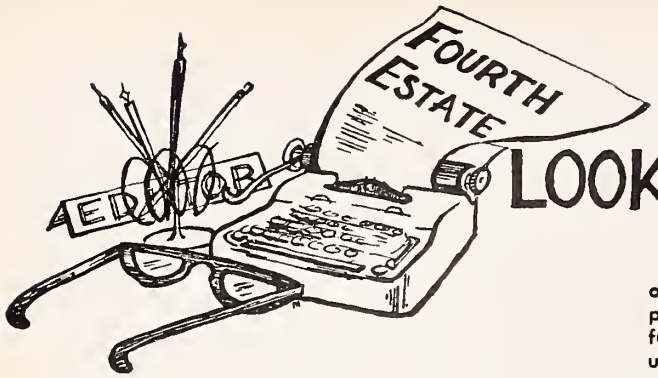

LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are af interest to the medical profession. Its function is to review comments which may be favorable or unfavarable to medicine. Members are invited ta submit editarial clippings for this column.

Why Muncie?

It's too bad the study committee which recommended Muncie as the best location for a second Indiana medical school didn't go on to say why.

The central Indiana city is a relatively short distance by interstate highway from Indianapolis, where the Indiana University Medical Center is located. The two schools might as well be placed across the street from each other.

We find it incomprehensible that the committee majority could shrug off the large and expanding population of northern Indiana.

A second puzzling aspect of the majority choice is its implied preference for Ball State University to operate the new medical school. By favoring a school that offers virtually none of the graduate level courses needed by medical students, the committee would unnecessarily prolong the time it will take to establish the new medical center and start turning out doctors.

Only three universities in Indiana offer the kind of graduate work a medical center requires: Indiana, Purdue and Notre Dame. Since Bloomington and Lafayette are not seeking the medical center, that leaves South Bend as the logical choice. But the committee majority, it seems, suspended logic.

The committee endorsement of Muncie is a blow to South Bend's hopes for the medical school, but the issue is far from decided at this point. The committee serves in an advisory capacity to the General Assembly, which need not follow its recommendations.

We hope the Assembly will weigh carefully and logically the cases of the communities contending for the medical school location. If it does, we think South Bend's patience will be rewarded. — *The South Bend Tribune*, Aug. 11, 1966.

New Medical Specialist

General practitioners, those reliable, personable, direct contacts with the medical profession many persons may have thought died out with the dinosaurs, may soon stage a comeback. The subject dominated the recent 115th annual convention of the American Medical Association in Chicago.

A convention address by the U.S. Surgeon General, Dr. William H. Stewart, emphasized the "missing link between the family, with its health needs, and the great hospitals where medical skills are increasingly concentrated." The missing link, he said, was a doctor who "can be the first port of call for the family in need of care."

Dr. Charles L. Hudson, the incoming AMA president, expressed the same sentiment in a different way. Pointing out that the ratio of doctors to the general population is increasing after years of a worrisome decline, Dr. Hudson commented that increasing numbers of doctors alone were not enough to ensure adequate medical care.

"The issue is not solely how much medical care is available, but how much demand people make for it and how it is distributed," he said.

The patient long has recognized a shortage of general practitioners. So, one might ask, now that the hierarchy of the profession publicly recognizes the fact also, what is going to be done about it?

A new specialty is the answer, in the view of many of the general practitioners at the convention. A specialty called "family physician." A man who can be called in any medical emergency, who can take care of any routine ailment or injury and who will have access to hospital facilities for routine operations. In short, a family physician.

The U.S. now has 300,000 doctors. Of these, 181,078 are in full-time private practice, and only 67,265 of these are general practitioners. The family physician concept has a major rebuilding job ahead of it to bring it back to the prevalence before the trend toward specialties, but taking official cognizance of the fact it is in reality a specialty in itself could do the trick. — *Terre Haute Star*, Aug. 12, 1966.

Crossing Medical Rubicon

Last Friday brought perhaps the most significant milestone in the history of American medicine. The long-heralded Medicare program finally went into operation, and, in the process, the die was cast for a vastly strengthened role for the Federal government in the medical care of the American people. If the United States had been lagging behind the rest of the world in making enormous strides of medical science available to its people, there undoubtedly would have been justification for massive Federal intervention. But the fact of the mat-

Continued

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ter is that it had not. Indeed, the United States is a world leader in both medical practice and medical education. Aspiring doctors who once studied in Vienna now come to the United States. Dignitaries who once went to Germany or Switzerland for treatment now come also to the United States. It is possible that these standards of excellence will be retained — even enhanced. But it is equally possible that in the United States, as in every other nation in which the dead hand of government has intervened, the practice of medicine will undergo a thorough transformation — a transformation from which the individual will ultimately be the sufferer.

As Medicare begins to unfold with its hospitalization benefits for the nation's elderly, it is a safe prediction that within a few years' time, its provisions will be extended step by step until all Americans are covered on a compulsory basis. Therein we think lies the real significance of Medicare's beginning.

The American people will be discovering during the next few months a glaring disparity between what is available and what they have been led to expect. And as Congress begins the task of filling in the chinks, American medicine will become progressively less free.

Medicare is now the law of the land. We hope as a result, that it works because the welfare of millions hangs in the balance and no one wants to see ailing Americans go unattended. But it is more with apprehension than with exhilaration that we watch this far-reaching innovation in America's medical machinery. — *Cincinnati Enquirer*, July 4, 1966.

Medical School Decision

The tussle to establish a new and separate medical school in Indiana and to locate the facility at South Bend, adjacent to the University of Notre Dame, has just begun. Recommendation of the state legislative committee to study medical education in Indiana that the new institution be placed in Muncie, home of Ball State university, is just that, a recommendation, and nothing more. Final decision will rest with the 1967 legislature.

Even the committee's earlier recommendation that Indiana have two medical schools instead of the sole one in Indianapolis at the Indiana University Medical Center, incidentally, the largest medical school in the nation, will have to be acted on by the legislators. The lawmakers could decide to retain the present medical school and add to it, which would mean no second school in any location. Or the lawmakers could decide to have a second school and then decide where it is to be.

The Ball State-Muncie community had been working for long months to bring the second medical school to Muncie, and their efforts proved fruitful as the committee decided in Muncie's favor. South Bend and Evansville were other sites which received committee members' votes.

Advocates of the South Bend location will continue to battle for their site. Chief argument for the South Bend location is that it is central in the rapidly growing northern Indiana area. It is accessible from Lake county in the far northwestern corner and from Fort Wayne in the northwest. It is in the midst of populous counties such as Elkhart, St. Joseph, LaPorte, Porter, Lake and not far from Allen county, where Fort Wayne is. It is estimated that by 1970, nearly two million people will be living in northern Indiana.

The South Bend advocates are quick to point out that Muncie is only about 60 miles northeast of Indianapolis, thus the two state medical schools would be relatively close together, much too close when population distribution is considered.

Notre Dame is prepared to offer some of its science facilities and a floor of its giant library for a medical school. Physicians of the area have offered to teach related programs at the school. Health care professions and hospitals of the area are behind the proposal. It is pointed out that South Bend is close enough to Illinois and Michigan to attract students from those states as well as from Indiana.

Lake county political leaders have been demanding the med school be built there, but the geographical location of that county is against it. The same objection can be made to the Evansville location.

If Lake county politicos and civic leaders can be persuaded to go with the South Bend and other northern Indiana groups plugging for the medical school, it is possible the legislature can be lined up for the South Bend site. There will have to be much persuading and log rolling done, however, between now and January — *LaPorte Herald-Argus*, Aug. 11, 1966.

Soaking The Poor

Thanks to the ever-wise precautions of our Federal government, Hoosier taxpayers will now be able to pay the medical bills of well-to-do citizens in New York.

Under Title 19 of the recently-launched "medicare" program, New York has created an aid program for the "medically indigent" which will allow people of substantial income, bills paid and money in the bank, to take a free ride medically at taxpayers' expense.

The Wall Street Journal notes that under the terms of the New York program, a family of four with a net income of $6,000 a year ($7,000 under some circumstances) "also may own a home and a car, have $3,000 in the bank, insurance of up to $1,000 cash value on each family member and unlimited term life insurance and still be considered too poor to pay medical bills."

In which case the bills will be picked up by a joint state-Federal program in which the Washington authorities would pour an estimated $217 million into New York. Similar schemes only slightly less generous are being devised in other states, schemes which all told

Continued

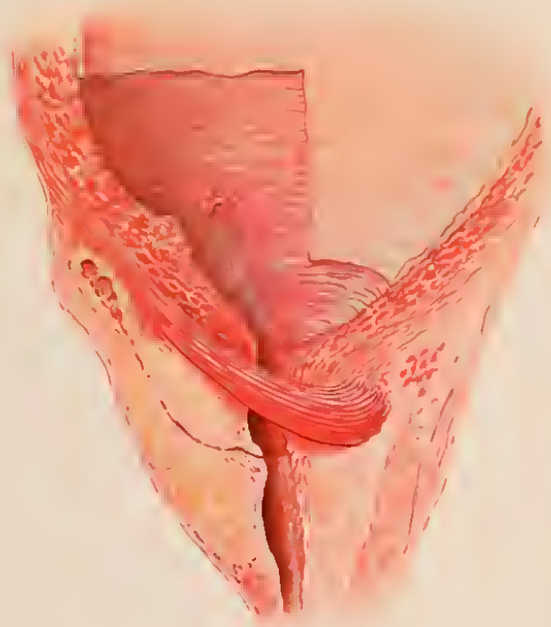
LIFT

GENITOURINARY TRACT SPASM

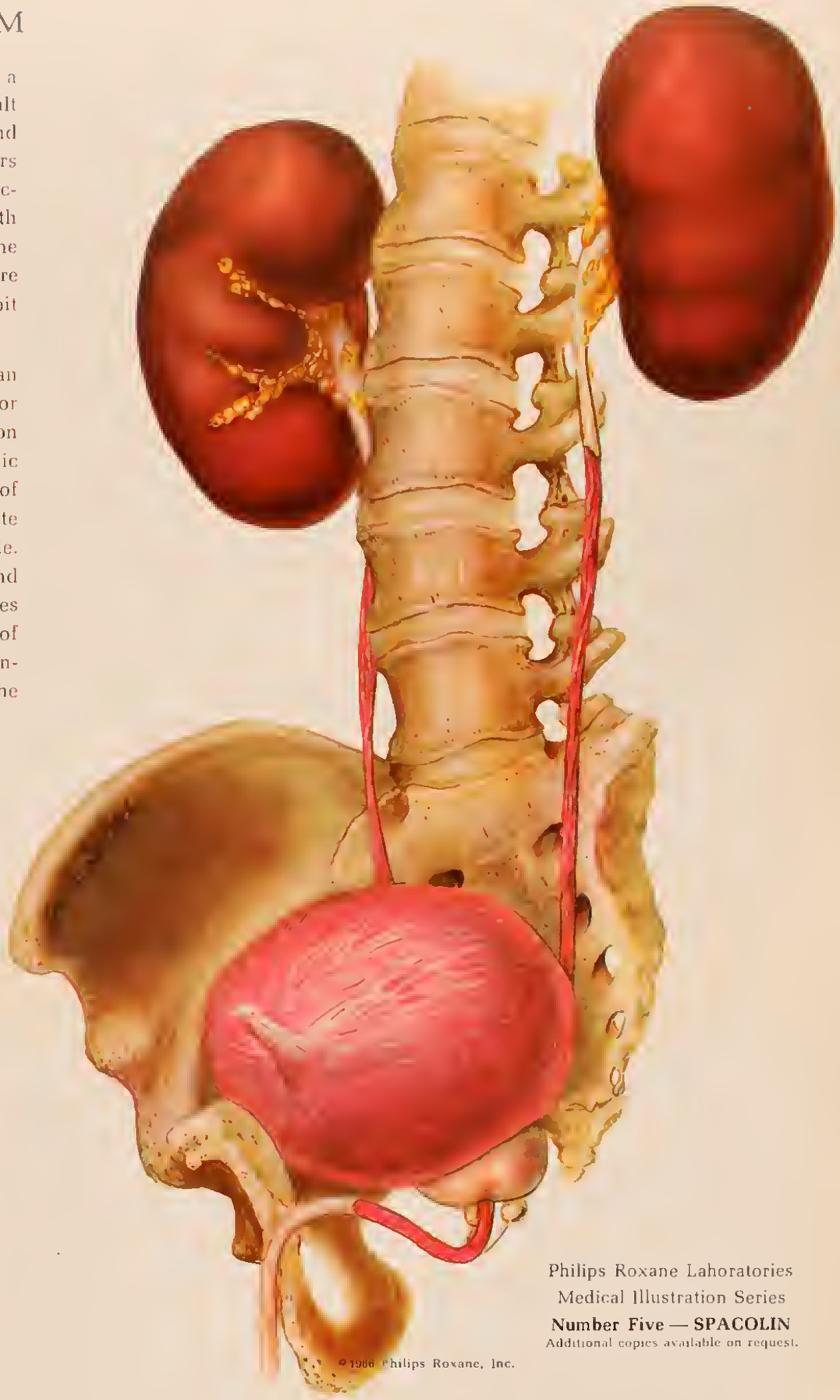
Spastic conditions of the genitourinary tract as a result of inflammation or calculi are often difficult to treat due to the combination of voluntary and involuntary neural control of the system. Urine enters the bladder in periodic spurts brought about by successive peristaltic waves that begin in the smooth muscle of the renal pelvis and pass downward. The normal anatomical constrictions of the ureters are of clinical importance because they frequently inhibit the passage of small calculi.

Abnormal distention of the bladder as a result of an obstructed outlet due to stricture of the urethra or an adenomatous prostate often requires consideration of the smooth muscle involved. Because prostatic tubules invade the internal smooth muscle layer of the urethra, unusual enlargement of the prostate impedes the sphincter-like action of this muscle. Micturition, with inflammation of the bladder and attending atonicity, is more frequent and in cases of long duration (e.g. tuberculosis) contracture of the bladder approaches a permanent state. The clinical importance of the smooth musculature in the urinary tract cannot be overemphasized.

SMOOTH MUSCULATURE OF THE URINARY TRACT



Artist's rendering of the urinary bladder illustrating the trigone, circular and longitudinal layers of smooth muscle. Note the spray of fibers which passes from the trigone to the wall of the urethra.



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Medical Illustration Series
Number Five — SPACOLIN
Additional copies available on request.

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The ureters are composed of three layers of smooth muscle, an inner longitudinal layer, a middle circular layer, and an outer longitudinal layer which course the entire length from the renal pelvis to the wall of the bladder where the ureters open as slit-like apertures for the most part retaining their own musculature. They are fairly uniform in size except for three slightly constricted portions, one at the ureteropelvic junction, the second at the pelvic brim, and the third at the extreme lower end of the ureter as it passes through the bladder wall.

The smooth musculature of the bladder is constituted in three general layers with poorly defined boundaries. The outer layer is composed mainly of longitudinal fibers which extend to the neck of the bladder where certain bundles unite to form a loop around the anterior surface of the vesical orifice. Within this loop, the circular layer forms a wedge below the outlet and flows down the urethra in an oblique direction surrounding the canal as a thin layer which, when stimulated, provides an upward pull on the urethral canal. The upward pull of this loop combined with the downward pull of the longitudinal layer gives a sphincter-like action to the musculature at the bladder neck although no true sphincter is present. The musculature of the trigone arises from the longitudinal muscle fibers of each ureter and spreads over the muscles of the bladder wall.

The male urethra is for the most part mucous membrane which contains loosely arranged longitudinal and circular smooth muscle layers. In the prostatic part at the neck of the bladder, the circular layer is highly developed and acts in harmony with the descending array of circular fibers of the bladder contributing to the sphincter-like control of the neck.

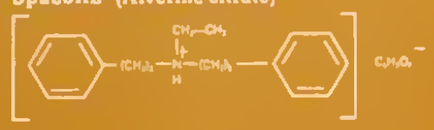
Spacolin (Alverine citrate) is a musculotropic antispasmodic which acts directly on the smooth muscle of the genitourinary tract with rapid onset and long duration. Because the parasympathetic nervous system is avoided, anticholinergic side effects do not occur. Moreover, Spacolin, (Alverine citrate) is ideally suited for relief of smooth muscle spasm in the presence of prostatic hypertrophy.

smooth muscle spasm

GENITOURINARY TRACT SPASM

PHARMACODYNAMICS OF SPACOLIN®
(Alverine citrate)

Spacolin (Alverine citrate)



- A potent musculotropic counter-spasmodic.
- Little or no effect on normal muscle tonicity and motility.
- Spasmolytic effect is 2½ to 3 times stronger than papaverine.
- Unrelated to atropine or atropine-like drugs.
- Therefore no atropine-like side effects such as dry mouth, blurred vision, constipation and urinary retention.
- Not contraindicated in glaucoma or prostatic hypertrophy.

FAST RELIEF OF SMOOTH MUSCLE SPASM

SPACOLIN®
(Alverine citrate)

Each tablet contains: Alverine citrate.....120 mg

INDICATIONS: Smooth muscle spasmolytic for use in spastic colon, spastic conditions of the gastrointestinal tract, biliary dyskinesia, cholecystitis, spasm associated with peptic ulcer,* achalasia, pylorospasm, spasm attendant to diarrhea, spastic conditions of the genitourinary tract attributable to inflammation and calculi, certain primary dysmenorrheas and as an aid in cystoscopic, esophagoscopic and gastroscopic examinations.

PRECAUTION: Caution is recommended when using in hypotensive patients.

SIDE EFFECTS: In common with other smooth muscle depressants, Spacolin temporarily lowers blood pressure.

DOSAGE: One tablet after meals 1 to 3 times daily at discretion of physician. When treating spasm associated with peptic ulcer, achalasia or pylorospasm, administer tablets ½ hour before meals. In dysmenorrhea, one tablet 3 times daily starting at onset of discomfort.

SUPPLIED: Bottles of 100 and 500–120 mg. tablets.

*Antacid and dietary measures are of primary importance in ulcer treatment and should not be neglected.

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are expected to boost Federal outlays for "medicaid," as this ingenious program is being called, to around $1 billion annually.

Who will pay for all this? The answer is that the ordinary taxpayers, many of whom make less than $6,000 a year and the majority of whom do not have as much as $3,000 in the bank, will pick up the tab. The hard-working Hoosier citizen who makes $4,000 or $5,000 a year will have to pay the medical bills for a New Yorker who is financially better off in every way.

Even more ominously these expanded outlays for "medicaid" will aggravate the already serious problem of inflation. To the extent such expenses are not met through increased taxes, they will add to the mounting Federal deficit, watering down the money supply and subtracting from the value of the housewife's shopping dollar.

The effects of this inflation were graphically illustrated in *The News* last week, when it was shown that a selected group of food prices in Indianapolis stores had jumped by 20% in the past six months. That price rise is caused — exclusively caused — by the splurge of handout programs in Washington like "medicaid" while the nation is trying to fight an expensive foreign war in Asia.

Either way, therefore, the answer is the same: It is the average taxpayer who is footing the bills for these exorbitant programs, allowing some comfortably well-off citizen in New York to foist his responsibilities on to someone else. This is an obvious injustice to hard-working citizens who mean to pay their own way. Perhaps even more important, it is also a certain recipe for the destruction of the dollar and national insolvency — *The Indianapolis Star*, July 12, 1966.

Medical School Reaction

The 1967 Indiana General Assembly will hear from us in northern Indiana. That became apparent Wednesday as reaction mounted against a recommended medical school site at Muncie.

The General Assembly's committee studying medical education, Tuesday shunned the northern Indiana bid to have a new medical school located near the University of Notre Dame. Northern Indiana spokesmen reacted immediately and justifiably so.

The legislative committee recommended Ball State University at Muncie as the top site for a proposed new medical school. The committee's choice, in our opinion, was unwise and hardly could have been based on facts. *The Truth* has pointed out on numerous occasions that all the facts lead to the Notre Dame plan as the superior one among those presented for committee consideration.

The legislative committee apparently decided to avoid those facts (as many felt it would) and make a recommendation based on political considerations and backed up by some shaky Ball State qualifications.

Fortunately, the committee's action is in no way binding. The General Assembly has the final say on any medical school decision.

The legislative committee's reasoning was a bit difficult for us to follow, and O. C. Carmichael, Jr., chairman of the Committee on Higher Education in northern Indiana, had similar difficulty.

In a prepared statement, Mr. Carmichael pointed out that the legislative committee recommended a site less than an hour's drive from Indianapolis, the site of the state's single medical school, although a principal objective in planning a second institution was to place it in an area where it would serve a new segment of Indiana's population.

What also is hard to figure is the apparent emphasis placed on Ball State's nursing school and work in medical technology, while the legislators seemed to pay scant attention to the world-renowned research facilities at Notre Dame.

Mr. Carmichael was not the only person in northern Indiana to rap the legislators' decision. Dr. Walter Compton, president of Miles Laboratories and another member of the Committee on Higher Education, said he will continue to press the advantages of the Notre Dame site. Others active in the drive reacted similarly, and still others are expected to do so.

To this group we add our voice. The legislative committee's recommendation was ill-advised, but it is not law. The Notre Dame site stands above the others, and we will not let that fact be ignored.—*The Elkhart Truth*, Aug. 11, 1966.

The Second Medical School

The scramble over the location of a second Indiana medical school is creating quite a rivalry between Muncie, South Bend, Evansville, Lake County and Indianapolis.

Of course, it is not certain that the legislature will approve plans and funds for another such school. But a legislative study committee which is examining medical education has recommended Muncie as the best location for one.

Muncie's case for having the school located there is that Ball State University would operate it. Ball State is deep in several fields associated with medicine, offering four-year courses in nursing, medical technology, manual arts therapy, premedical and predental education.

South Bend is arguing that Ball State offers virtually none of the graduate level courses needed by medical students, whereas Notre Dame University does. As a further argument, South Bend leaders say that a principal objective in planning a second institution is to place it in an area where it would serve a new segment of the state's population, and that Muncie is less than an hour's drive from Indianapolis, site of Indiana's single medical school.

Evidently the legislature will be called on to make a choice between a new school in some other city and an Indiana University plan for revision and expansion of the I.U. School of

medicine at Indianapolis. The I.U. plan proposes a 25% expansion in the existing school, at an estimated cost of $6 million, in addition to another $6 million of construction.

One basic feature of the I.U. plan has been indorsed by the study committee. This is to develop a substantial number of new openings for intern and resident training, by cooperative arrangements with hospitals throughout the state. The I.U. faculty says that inadequacy of such openings is one of the bottlenecks in present preparation of physicians in Indiana.

The Muncie plan is to build a medical center on state-owned ground on the Ball State campus, and construction costs have been placed at about $38 million. Of that total $13 million would be financed by the state and the remainder would come from gifts, foundations and federal funds. A not-for-profit organization has been formed by business, labor, civic and professional groups in Muncie to raise funds for the project.

There seems to be a rather general consensus that the state's medi-education facilities need to be enlarged. Indiana's ratio of doctors to population — 86 to 100,000 — is well under the nation's average.

If a second school is to be created, a principal determinant for its location should be the cost. The study committee needs to have the cost estimates on all the possible alternatives. The people who are going to pay for the school, if one is established — and that means the taxpayers — will be interested in the proposition that costs them the least.

This is not to say that the matter should be approached in a niggardly way. Indiana people would want whatever medical school expansion is chosen to be first-rate. But they would not appreciate the selection of the costliest plan if a suitable, adequate and less expensive one could be adopted. — *Kokomo Tribune*, Aug. 16, 1966.

A Doctor For Redkey

The enthusiastic determination of a good many Redkey people to secure a doctor for their town is remarkable for two reasons. In the first place, it represents a display of civic-mindedness by a community in which, for the past few years, community spirit seemed to be dying a slow and tortuous death. Second, the particular problem they are tackling is so great that it may well prove insurmountable.

It is safe to say that Redkey has no physician at present because the town is (1) small and (2) easily accessible to medical facilities in both Dunkirk and Portland. It is true that Ridgeville, a town half the size of Redkey, was successful in finding a doctor last year. It is also true that Fort Recovery and Geneva, both smaller than Redkey, support physicians of their own. But these three towns are a good deal more isolated than Redkey is; thus, they have a greater need for a doctor.

On the other hand, the situation is far from hopeless. Stranger things have happened in Redkey. In spite of the close proximity of two larger cities, the McCord's store in Redkey draws business from a wide area which stretches from Pennville to Ridgeville. Shambarger's Restaurant boasts of customers from all over the country and, in fact, all over the world. If a good store and a good restaurant can succeed in Redkey, it's possible that a good doctor could, too.

Our point is that doctors are in short supply, and should the Redkey committee fail in its effort, we hope Redkey people won't conclude from the experience that united community action is not worthwhile. A few months ago Redkey published an attractive folder advertising the town's assets, and the present response to the search for a doctor shows that there are many people in Redkey anxious to work positively for the good of the town.

They can be sure that the only way a small town will survive in today's urbanized age is by standing up to the challenges of the present and future. We hope the people of Redkey get their doctor; they're certainly going about it in the right way. But if they find themselves running into a stone wall, we hope they'll carry their aggressive approach into other projects and other fields. — *Portland Commercial-Review*, Aug. 9, 1966.

Belated Study

When it enacted the big new Medicare program for the elderly, Congress felt it only fair to improve health plans already available for the medically indigent in various categories. So it added Section 19 to Medicare — and is now wondering hard whether it won't have to curtail the expenditures originally authorized.

The cost estimates on which it acted called for about $238 million in first-year Federal grants for joint Federal-state medical programs. But the first seven states to qualify ran the Federal tab well over $238 million and New York State rushed into a plan — now being modified — which would have provided free medical, dental, hospital and nursing services to 7 million of her 18 million population and cost Federal taxpayers $139 million in that one state alone.

The episode indicates that Congress will have to sharpen its understanding of just what is happening in the new welfare programs. The first Government interventions were relatively modest in scope, relatively narrow in coverage, and relied heavily on special revenues to which prospective beneficiaries contributed. The new plans are increasingly inclusive both in the number of beneficiaries and in the assistance offered, and there is steady pressure for non-contributory financing directly out of the Federal treasury.

What is happening is that the Federal Government is asked increasingly to decide what share of national resources shall go to very large numbers of individual citizens, a decision left in simpler and, if one will, less compassionate times, to the play of market forces which rationed individual consumption more closely to individual

production. The fact that the Government makes the decisions does not, however, in itself increase the volume of goods and services to be distributed and if political agencies try to distribute more than there is, market forces will inexorably reassert themselves by way of spiral storms of price inflation. — *The Baltimore Sun.*

Physician To Receive Award

The Mental Health Association in Indiana will present the second annual award to a physician in Indiana for outstanding service to the mentally ill.

According to Paul E. Reinken, chairman of the Awards Committee, the presentation will be made at the meeting of the Indiana State Medical Association in October.

The first award was presented last year to Dr. Betty Dukes of Dugger, Indiana, who at that time was president of the Mental Health Association in Sullivan County.

An award of $1,000 will be presented to the Department of Psychiatry of a medical school chosen by the recipient of the award for a mental health purpose. The award will be given to the medical school in the name of and in honor of the recipient.

Any physician in Indiana is eligible to be nominated except those who serve as psychiatrists or physicians working full or regular part-time in the care of the mentally ill at state hospitals or other mental health facilities.

Nominations may be made by local medical societies, county mental health associations or individual citizens of Indiana.

Nominations must be submitted on an official entry blank, which is available from the Mental Health Association in Indiana, 615 North Alabama Street, Indianapolis, Indiana 46204.

Nominations must be submitted by Sept. 15. — *Howard County News & Observer*, Aug. 18-19, 1966.

Life or Death

The death of a Hammond Noll football player a few days ago was a tragedy. Benjamin Stur, 17, died shortly after suffering a head injury in practice.

Yes, his death was tragic, and the tragedy will be compounded if his case is not used as further stark evidence that Lake County needs a medical school and the facilities that go with it.

No criticism of anyone involved in the case — the coach, parents, physicians, or hospital officials is intended nor is any justified.

It is possible that if Lake County had had a modern medical center, staffed with experts, young Stur could have been saved. It might have been possible for them to make a speedy diagnosis, and to perform immediate surgery.

There are no such facilities in Lake County, whose hospitals are overcrowded, understaffed and admittedly unable to do the job they want to do. The county is woefully short of physicians. Where are the interns? They just don't come here. Physicians who must be on call at hospitals are taking further time away from their regular patients. This is not an indictment of hospitals or of doctors, but of the system, a system that can lead to more tragedies if it is not corrected.

In cases like that of young Stur, time is vital. When physicians are forced to send such patients to a Chicago hospital for treatment, valuable time is lost, but it is the best they can do.

Obviously a medical school would attract more interns, more physicians, more lifesaving facilities and skills of all kinds. Saying we need it is not enough — the fact is, it is a life and death matter.

Lake County has lost out in the first round of the battle for the site, but the cause is not dead. Our legislators are primed to keep up the fight, and so are those who have worked to present the area's case to downstate officials.

We may lose the final decision, but the enthusiasm that has characterized the drive for more facilities should not be allowed to die. It won't die if we remember a boy named Benjamin Stur, who did. — *Gary Post-Tribune*, Aug. 21, 1966. ◄

August 29, 1966

Mr. Charles Walter
Senior Associate Editor
MEDICAL ECONOMICS
Oradell, N. J. 07640

Dear Mr. Walter:

In reference to your article, "Answers to your Medicare Questions", in the August 22 issue of MEDICAL ECONOMICS, pages 146 and 147, the information contained in your answer to question No. 2 is incorrect as it pertains to Indiana Blue Shield.

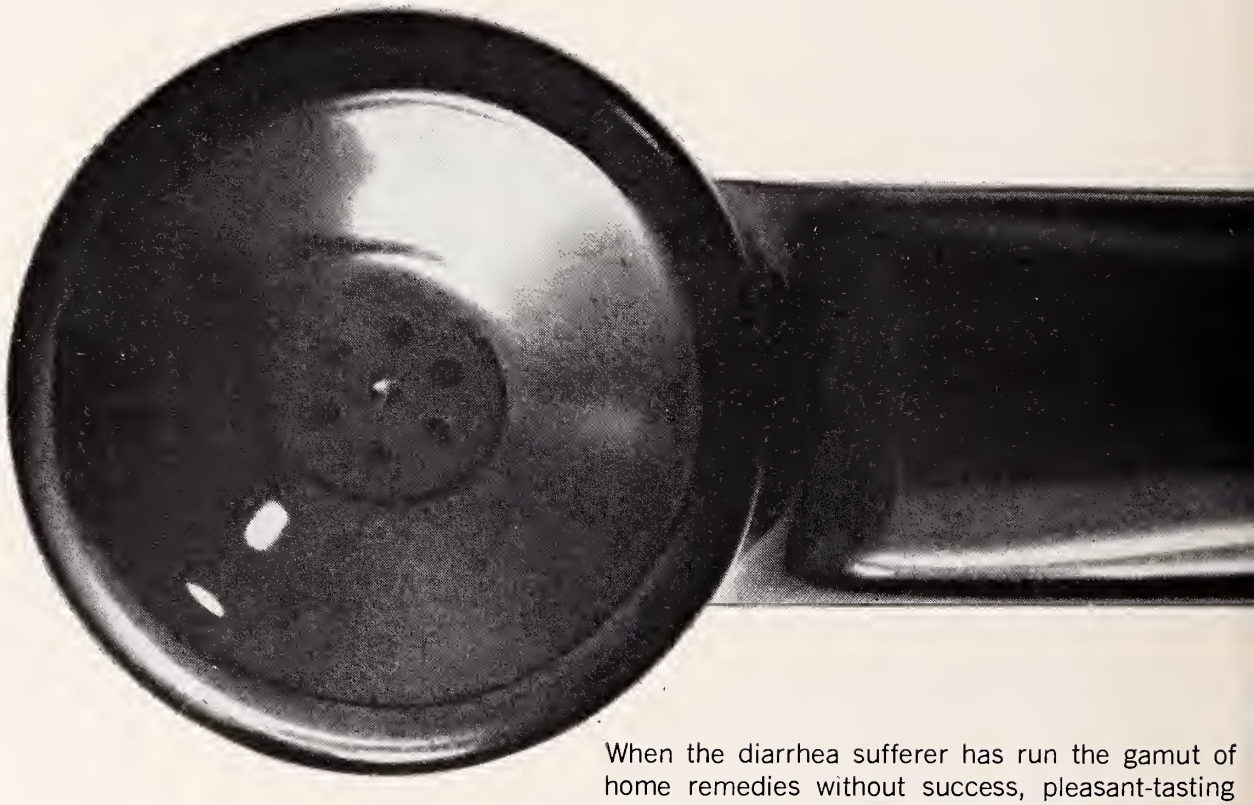
Indiana Blue Shield provides no coverage for home and office calls under the basic portion of our Medicare Supplement Program. The only area in which home and office calls would be covered is under the Major Medical provisions under which a patient must satisfy a deductible of $100 per calendar year.

Once this deductible has been satisfied, we would cover home and office calls on an 80-20 coinsurance basis.

I am enclosing a copy of our brochure for your files.

Sincerely,
MUTUAL MEDICAL
INSURANCE, INC.
Richard C. Kilborn
Executive Vice President

When uncontrolled diarrhea brings a call for help



When the diarrhea sufferer has run the gamut of home remedies without success, pleasant-tasting CREMOMYCIN can answer the call for help. It can be counted on to consolidate fluid stools, soothe intestinal inflammation, inhibit enteric pathogens, and detoxify putrefactive materials — usually within a few hours.

CREMOMYCIN combines the bacteriostatic agents, succinylsulfathiazole and neomycin, with the adsorbent and protective demulcents, kaolin and pectin, for comprehensive control of diarrhea.

INDICATIONS: Diarrhea.

CONTRAINDICATIONS: Do not use in intestinal obstruction, extensive ulceration of bowel, or diverticulosis; in hypersensitivity to sulfonamides or neomycin; in pregnancy at term, in premature infants, or during first week of life in the newborn.

WARNINGS: Use only after critical appraisal in patients with hepatic or renal damage, urinary obstruction, or blood dyscrasias. Fatal hypersensitivity reactions and blood dyscrasias reported with use of sulfonamides. Consider periodic blood counts, hepatic and renal function tests during intermittent or chronic use.

PRECAUTIONS: Succinylsulfathiazole: Use with caution if there is history of significant allergies and/or asthma. Continued use requires supplementary vitamins B_1 and K. *Neomycin:* Watch for

your ℞ for Cremomycin can provide relief

curare-like neuromuscular block during anesthesia if neomycin is used preoperatively in large doses when renal function is poor; watch for overgrowth of nonsusceptible organisms. Consider possibility of ototoxicity and nephrotoxicity with prolonged high dosage.

SIDE EFFECTS: As with all sulfonamides: Headache, malaise, anorexia, G.I. symptoms, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, rash, conjunctival and scleral injection, petechiae, purpura, hematuria, and crystalluria have been noted. Reduced fecal output of thiamine and decreased synthesis of vitamin K have been reported. *Neomycin:* Nausea, loose stools.

Before prescribing or administering, read package circular with product or available on request.

promptly relieves diarrheal distress

Cremomycin®

ANTIDIARRHEAL

Composition: Each 30 cc. contains neomycin sulfate 300 mg. (equivalent to 210 mg. of neomycin base), succinylsulfathiazole 3.0 Gm., colloidal kaolin 3.0 Gm., pectin 0.27 Gm.

MERCK SHARP & DOHME Division of Merck & Co., Inc., West Point, Pa.

where today's theory is tomorrow's therapy

berg[11] and others then reported series using pyloroplasty as their drainage procedure.

Johnson and Orr,[12] Scott,[13] Zollinger,[14] the senior author[9] and others[15] advocated hemigastrectomy and vagotomy as the operation of choice for duodenal ulcer. Simpler definitive procedures led naturally to exploration of their use for bleeding or perforated ulcers. Farris and Smith[16] among others have championed this view.

In order to contribute to medical progress, large medical centers must stay with one procedure long enough to statistically analyze its safety and potential, hence the term "policy operation."

In the large community private practice of surgery, we are under no such compunction to have a "policy operation," nor are we resident surgeons learning the rudiments of surgical science. Rather, the good community surgeon in a secondary medical center can use all those contributions of the large teaching centers, but use them on a case-to-case basis, individualizing each patient.

We decided to apply this principal to the treatment of ulcer disease beginning January 1, 1955. Our series numbered 711 cases and the cut-off point was January 1, 1965. The oldest patient was 89 years of age while the youngest was 16. The average was 57.4 years. Two hundred-twenty patients were women and 491 were men. One hundred seventy-eight ulcers were gastric and 533 were duodenal. In each case, that operation deemed to be the safest and simplest, which still fulfilled the criteria of adequacy, was used. The results of this ten-year study make up the body of this paper.

We sincerely feel that the simpler definitive procedures presently available allow us to extend the comfort and protection of a definitive ulcer operation to many persons previously not safe candidates because of concurrent disease, exsanguinating hemorrhage, perforation, debility or frailness of any nature. Our feelings concerning timing and selection of procedure will become obvious. We used no selective vagotomies because of fear of recurrence. In our hands, high gastrectomy is reserved for that high gastric ulcer whose malignant potential is not resolved by frozen section. If this ulcer is benign, excision, vagotomy and a Kelling-Madlener[17] resection is our treatment of choice.

In all clinics surgery is used for hemorrhage, perforation, obstruction, fear of malignancy and intractability of disease or patient.

It is difficult, as Hoerr[18] points out, to scientifically assess the results of ulcer surgery, since so much of a satisfactory result depends on the patient's subjective opinion of the result. Living close to our results makes this factor simple to assess. This is not always true in a large metropolitan center. The hope underlying this presentation is that the skillful use of all the proven procedures available, when blended with individual evaluation of one patient at a time, will ultimately bring us closer to the end goal of more complete patient satisfaction.

The Problems of Hemorrhage

First let us consider hemorrhage. We can all agree, I daresay, that the two remaining obstacles to further improvement in this group are first, excessively prolonged attempts at medical management, and second, excessive frailty of the elderly exsanguinated patient. The first may be ameliorated by patience, violently and occasionally punctuated by impatience, while the second we believe can be improved by accepting the fact that gastric resection is no longer the only good definitive operation available. The simpler operation will stop the bleeding; offer an excellent chance of cure and in addition, frequently present you a patient for resection under more favorable circumstances should this become necessary. Should the patient fail to survive the first intervention, he will not be available for a second. This is a real surgical truism.

Our routine in hemorrhage is simple. One thousand to 1,500 cc's of blood are given rapidly. If the patient does not stabilize and remain stable, in the absence of concurrent disease, he immediately becomes surgical. If blood is dribbled slowly and endlessly, the bleeding is obscured and the point is reached wherein surgery, the only hope, is impossible. When surgery is selected, the blood is continued until a plateau of vital signs is reached and the operation follows immediately. In choosing the correct procedure, the two primary considerations are a ready understanding of the procedures available, and the surgeon's willingness and ability to assess his own technical facility.

We use an upper mid-line incision. If the ulcer is in the lower half of the stomach and no local or general contraindications exist, a vagotomy (Figure I) and hemigastrectomy (Figure II) are done. If the ulcer is high and wedge excision proves it benign, vagotomy and distal hemigastrectomy are done. If the patient is old or frail or tolerates the hemorrhage or trauma of surgery poorly, a cancer negative wedge excision of the ulcer dictates a vagotomy and pyloroplasty. We have treated 76 patients with bleeding gastric ulcer. The mortality was three deaths or 3.72%.

If the ulcer is duodenal; has not penetrated into the pancreatic head; is near the pylorus; is not the center of a hopeless area of induration and the patient is tolerating the surgery well, a

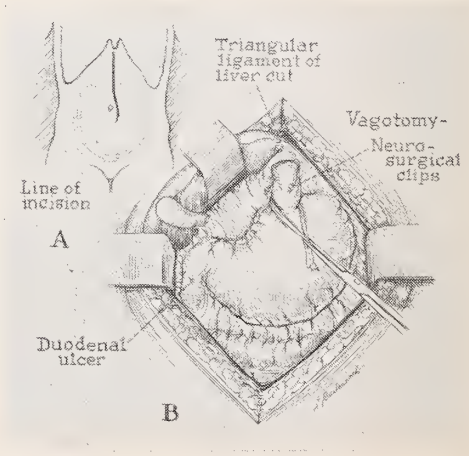


FIGURE I

INSERT (A) shows incision of choice. Main figure (B) shows vagotomy (subdiaphragmatic).

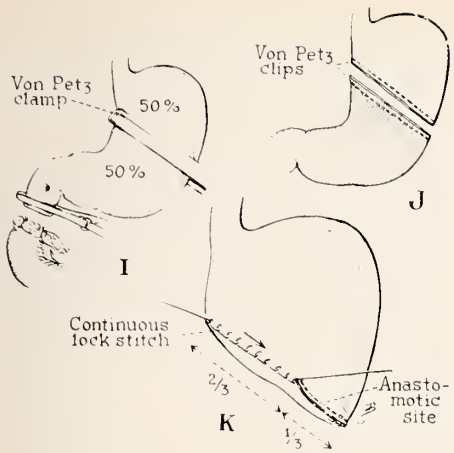


FIGURE II
THREE steps in hemigastrectomy are depicted in preparing for a Billroth II reconstruction.

vagotomy and hemigastrectomy are done, making no effort to excise the ulcer if its location demands compromise of safety. Intentional duodenostomy is relatively inexcusable when operations are available which make it unnecessary. If any of the listed conditions do exist, the ulcer is oversown with an adequate number of non-absorbable sutures (Figure III), placed at right angles to the axis of the pancreaticoduodenal vessels, biting deeply into the lips and base of the ulcer. Digestion makes catgut unsuitable. This sewing is done through a longitudinal pyloro-duodenotomy which is then closed transversely with one layer of interrupted sutures, and vagotomy is added (Figure IV). If scarring of the duodenum makes transverse closure undesirable, a Finney pyloroplasty after duodenal mobilization is a simple solution (Figure V). Here also the gastroenterostomy may rarely come into its own. We have treated 200 cases of duodenal ulcer with bleeding and seven patients have died. The mortality is 3.5%. Hemigastrectomy and vagotomy were used on 76 while 124 had lesser procedures.

Gastric Perforations

Our criteria for perforation also involves individual consideration. For many years simple closure was the only safe surgery in these patients. Ultimately 50 to 60% came to recurrent grief. In the past 15 years, surgeons have

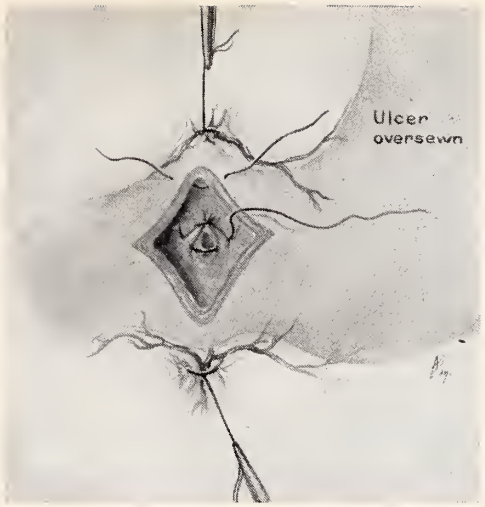


FIGURE III
OVERSEWING of duodenal ulcer through a longitudinal pyloromyotomy. Non-absorbable sutures are necessary.

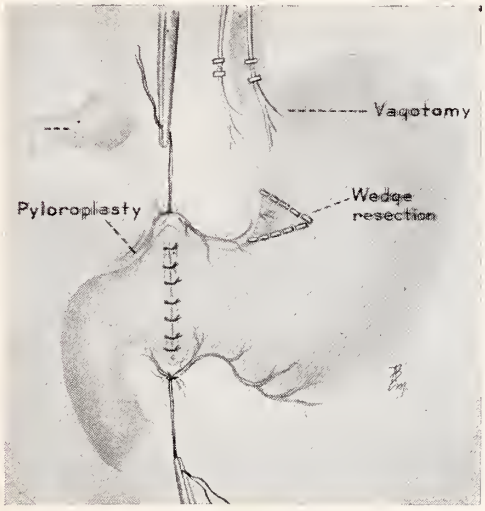


FIGURE IV
CONVERSION of pyloromyotomy to pyloroplasty as well as wedge excision with clips.

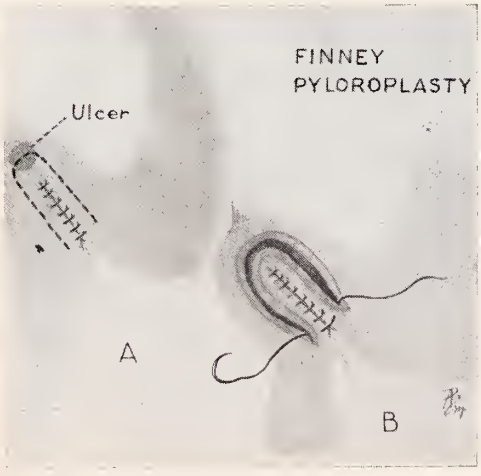


FIGURE V
TECHNIC of Finney-Von Haberer pyloroplasty is depicted.

divided into those who still advocate no other operation, and those who feel definitive surgery is frequently possible. If gastric resection is the only definitive procedure considered, those who advocate simple closure have statistics on their side. If one is willing to consider the lesser procedures, a considerable number of these patients can be handled definitively. Our criteria for perforation are much like those for hemorrhage, except that a lesser percentage of gastric resections are done.

An arbitrary time limit of 12 hours is set, beyond which few definitive procedures are done. If the perforation is gastric; is in the distal stomach; is without excessive fixation, induration or edema, and the patient is vigorous, vagotomy and hemigastrectomy are done. With a high ulcer the ulcer is closed and the same procedure followed. If the perforation is old; the patient physiologically aged; contamination is severe; attachment is solid; or the patient is tolerating the procedure poorly, the hole is closed and vagotomy and pyloroplasty are done. Malignancy is neglected because a cancer operation is not feasible under these circumstances. Our series includes 60 gastric perforations of which 24 were resected and 36 had the conservative procedure. There were two deaths. The mortality was 3.3%.

If the perforation is duodenal, vagotomy and hemigastrectomy are used only if induration, attachment to the pancreas or involvement of the porta hepatis are minimal or absent in a patient in otherwise good condition. If the conditions are otherwise, closure with vagotomy and pyloroplasty is resorted to as in bleeding ulcers. Since most of these ulcers are relatively anterior, a pyloro-duodenotomy either goes through the ulcer or incorporates it by excision. When severe induration or scarring is present, the Finney-Von Haberer pyloroplasty (Figure V) as suggested by Hendry[19] has allowed us to offer many of these patients a definitive operation. Our series includes 136 duodenal perforations with six deaths, a mortality of 4.4%. Hemi-

gastrectomy and vagotomy were used in 36, while 100 had the conservative procedure. This series includes only those perforations treated definitively which constitutes 45% of the total operated on in this ten years.

When obstruction indicates surgery, careful hydration, decompression and electrolyte repair ordinarily allows for safe definitive surgery. For aged or infirm patients or those with little or no free acid capabilities, gastroenterostomy still has a place. If conditions are favorable, vagotomy and hemigastrectomy are preferred. If acid and risk are high, vagotomy and pyloroplasty come into their own.

Since definitive surgery for duodenal ulcer has become much more common, surgery for late obstruction is much less common. Our series includes 33 patients operated upon for obstruction with one death, a mortality of 3.3%. This one death occurred on the third postoperative day as a result of a ruptured myocardium which followed a silent preoperative myocardial infarct. There were 18 resections, 13 pyloroplasties and two gastroenterostomies.

Fear of malignancy needs only a word, since it can be quickly dispelled or affirmed by frozen section. If malignancy is present, the treatment is outside the scope of this paper. If not, the choice of procedure is the same as that already presented.

Intractability

Ulcer intractability covers a multitude of sins. It has come to apply to that ulcer whose signs and symptoms go on unabated despite medical management or because the patient cannot or will not follow the management. The quality of medical management is hard to assess, as is the diligence of the patient in following it. In effect then, the patient who is disabled in the presence of medical management must be considered for surgery. One generality must be stated. The more he confines his complaints to his ulcer; the more severe has been his specific pain; the more typical are his x-rays; the higher is his collected free acid, and the longer he has had trouble, the better are his chances for an excellent result. In the absence of these criteria, your competitor or the nearest medical center is a logical place for him to go.

Our series includes 206 patients operated because of intractability. Gastric ulcers were present in 42 while 164 were duodenal.

In gastric ulcer, the criteria are the same as with hemorrhage. These are all done electively so that a higher percentage can have the ideal operation whether the ulcer is proximal or distal. We reserved high gastric resection for two ulcers wherein frozen section did not unequivocally rule out malignancy. Neither of these patients died. Hemigastrectomy and vagotomy were used in 34 or 81% of the patients with intractable gastric ulcers, while high gastrectomy was used for two and excision of the ulcer with vagotomy and pyloroplasty for six. There was one death, a mortality of 2.4%.

Among the intractable duodenal ulcers, the criteria are roughly the same as with hemorrhage or perforation. One must, in addition, consider the relatively good condition of the patients in this group. In spite of this we demand a free acid of 50 mEq. or more in a patient of ulcer temperament before considering a gastrectomy of any sort. As the ten years of the study wore on, we became more inclined to use vagotomy and pyloroplasty and less inclined to do gastrectomies. We are persuaded that a wide open pyloroplasty with one layer of sutures and no attempt to disguise the dog ears is the sine qua non of success. Gastric stasis with stimulation of the gastric phase is the harbinger of disaster.

Gastroenterostomy is reserved for that patient whose ulcer is dangerous to resect but whose scarred pylorus and duodenum forbid adequate pyloroplasty by any method. These are few. They are all done in front of the colon because if recurrence occurs, it will be at the stoma; the duodenum will be simple to handle and risk will be minimal. Among eight patients who had vagotomy with gastroenterostomy, two marginal ulcers developed (25%) both later resected with good results and no mortality.

Among the remaining 156 patients, 72 had vagotomy with hemisgastrectomy with no bona fide recurrence and two deaths for a mortality of 2.8%. Eighty-four had vagotomy and pyloroplasty with no deaths and one recurrence as a perforation. This patient had a resection and recovered after a stormy convalescence marred by a sub-hepatic abscess. He is well and content with his result.

Follow-up is accurate and complete in 675 of the 711 patients or 95%. Results are excellent in 600 or 88%; good in 46 or 6.8% and poor in 29 or 5.2%. The 5.2% includes all the deaths.

Table I shows a summary of the results in the various categories. Table II summarizes the overall results. Two "very special" patients had vagotomy and pyloroplasty two years ago for penetrating duodenal ulcer. Each has poor eating habits, necessarily due to their occupation to some extent; each lives in a highly ulcerogenic environment with an impossibly difficult taskmaster. They have no recurrence and, indeed, are the co-authors of this paper and my associates — Drs. Patterson, Voorhees.

Table I – RESULTS by CATEGORY

LOCATION of ULCER	No. CASES	COMPLICATION	OPERATION	DEATHS	PERCENT
GASTRIC	76	HEMORRHAGE	VAG. and HEMIGAST. WEDGE EXCISION VAG. and PYLORO.	3.0	3.72
DUODENAL	200	HEMORRHAGE	VAG. and HEMIGAST. - 76 VAG. and PYLORO. - 24	7.0	3.5
GASTRIC	60	PERFORATION	VAG. and HEMIGAST. - 24 CLOSURE with VAG. and PYLORO. - 36	2.0	3.3
DUODENAL	136	PERFORATION	VAG. and HEMIGAST. - 20 VAG. with PYLORO. - 100	6.0	4.4
DUODENAL	33	OBSTRUCTION	VAG.-HEMIGAST.-18 VAG. PYLORO.-13 GASTRO-ENT.-2	1.0	3.3
GASTRIC	42	INTRACTABLE	HIGH GAST. - 2 VAG.-HEMIGAST.-34 EXC. VAG. and PYLORO.-4	1.0	2.4
DUODENAL	164	INTRACTABLE	VAG. and G.E. — 8 VAG. & HEMIGAST.-72 VAG. & PYLORO.-84	2.0	2.8

Table II — 711 CASES ANALYSES of OVERALL RESULTS		
CATEGORY	NUMBER	PERCENT
AVAILABLE TO FOLLOW-UP	675	95%
EXCELLENT RESULTS	600	88%
GOOD RESULTS	46	6.8%
POOR RESULTS.	29	5.2%
TOTAL DEATHS	22	3.2%

Summary

Beginning January 1, 1955, an effort was made to individualize all ulcer patients and to offer definitive surgery whenever possible — even in the face of complications. The mode of selection of procedure in each of the major categories and the results of the method are presented. We believe that the conservative, yet definitive operations now available, offer much in decreased mortality and increased patient satisfaction.

BIBLIOGRAPHY

1. Moore, F. D.: Surgery in Search of a Rationale, *Am. J. Surg.* 105:304-312, 1963.
2. Edkins, J. S.: The Chemical Mechanisms of Gastric Secretion, *J. Physiol.* 34:133-144, 1906.
3. Edkins, J. S., Tweedy, M.: The Natural Channels of Absorption Evoking the Chemical Mechanism of Gastric Secretion, *J. Physiol.* 38:263-267, 1908.
4. Latarjet, A.: Resection des nerfs de L'estomac. Technique Operatoire. Resultat Cliniques, *Bull. Nat. Acad. Med.* 87:681-685, 1923.
5. Pieri, G., Tauferna, U.: Studi Sulla, fisiologica dell'innervazione viscerale dell'uomo: effeti della resozione del vago sulla secrezione gastrica, *Riforma Med.* 46:323-329, 1936.
6. Pieri, G.: Bilateral Subdiaphragmatic Resection of the Vagus Nerves, *JAMA* 98:1950-1952 (abstract), 1932.
7. Pavlov, I. P.: *The Work of the Digestive Glands,* translated by W. H. Thompson, New York, J. B. Lippincott Company, 1910.
8. Dragstedt, L. R., Owens, F. M., Jr.: Supradiaphragmatic Section of Vagus Nerves in Treatment of Duodenal Ulcer, *Proc. Soc. Exper. Biol. and Med.* 53:152-159, 1943.
9. Bolman, R. M., Lloyd, R. P.: Surgical Experiences with Three Hundred-Sixteen Duodenal and Marginal Gastric Ulcers, *AMA Arch. of Surg.* 70:833-842, 1955.
10. Dragstedt, L. R.: Vagotomy for Peptic Ulcer, *Am. J. Med.* 8:409-411, 1950.
11. Weinberg, J. A.: Vagotomy and Pyloroplasty in the Treatment of Duodenal Ulcer, *Am. J. Surg.* 105:347-351, 1963.
12. Johnson, H. D., Orr, I. M.: Surgical Policy for Peptic Ulcer, *Lancet* 1:253-257, 1953.
13. Edwards, L. W., Edwards, W. H., Sawyers, J. L., Gobbel, W. G., Jr., Herrington, J. L., Jr., Scott, H. W., Jr.: The Surgical Treatment of Duodenal Ulcer by Vagotomy and Antral Resection, *Am. J. Surg.* 105:352-360, 1963.
14. Zollinger, R. M.: Technique of Vagotomy, Hemigastrectomy, and Billroth I Anastomosis, *Am. J. Surg.* 105:413-422, 1963.
15. Harkins, H. N., Stevenson, J. K., Jesseph, J. E., Nyhus, L. M.: The Combined Operation for Peptic Ulcer, *AMA Arch. Surg.* 80:743-752, 1960.
16. Farris, J. M., Smith, G. K.: Vagotomy and Pyloroplasty for Bleeding Duodenal Ulcer, *Am. J. Surg.* 105:388-395, 1963.
17. Madlener, M.: Pylorectomy in Gastric Ulcer, *Zentralbl. Chir.* 50:1313-1316, 1923.
18. Hoerr, S. O.: Symposium on the Treatment of Duodenal Ulcer, *Am. J. Surg.* 105:291-292, 1963.
19. Hendry, W. G.: The Finney Pyloroplasty in Gastroduodenal Surgery, *Surg., Gyn., and Obstet.* 116:657-661, 1963. ◄

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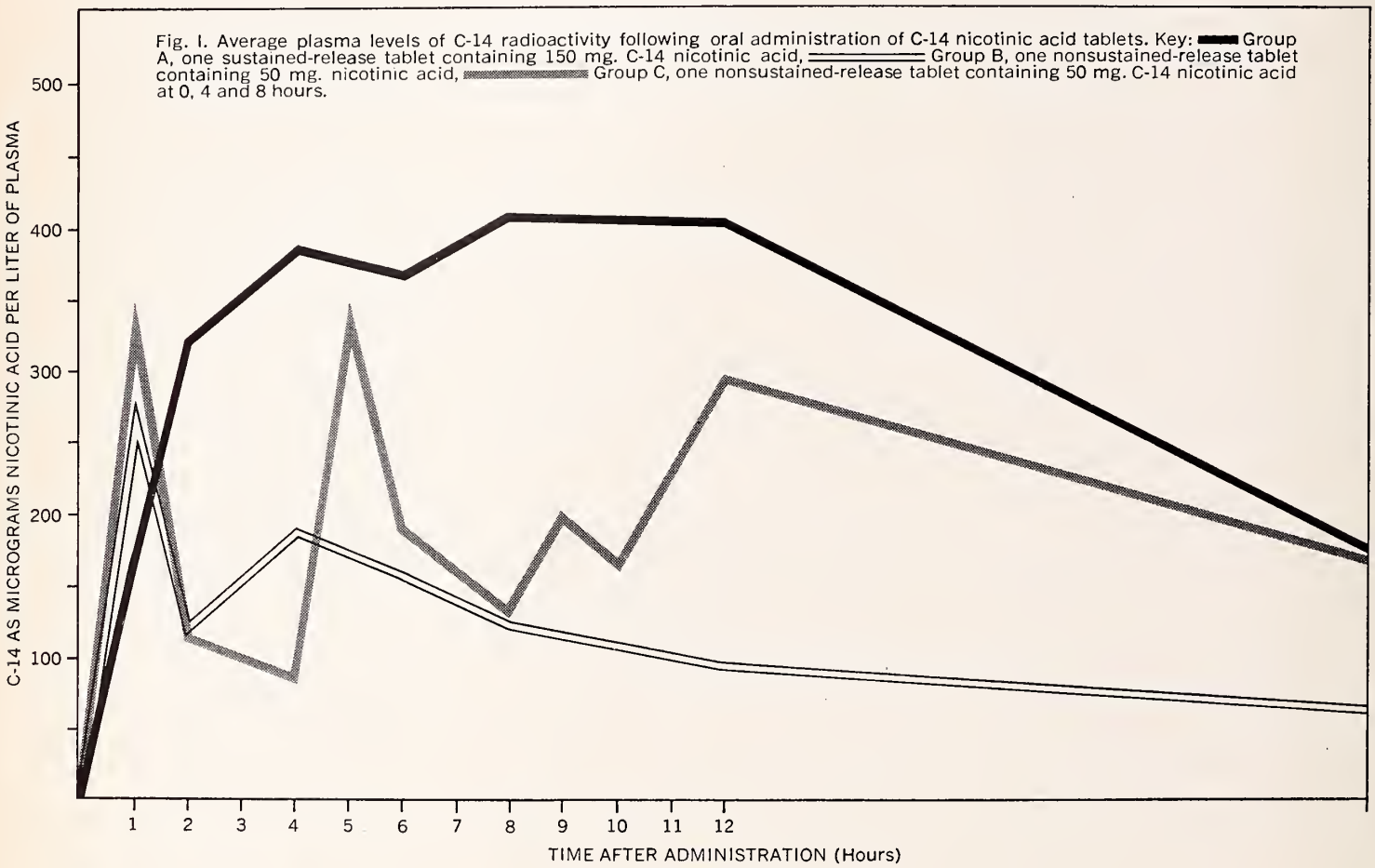

(fewer absent doses by absent-minded patients)

Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

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Geroniazol TT improves the typical, unfortunate, signs of senile confusion. Patients become more alert,

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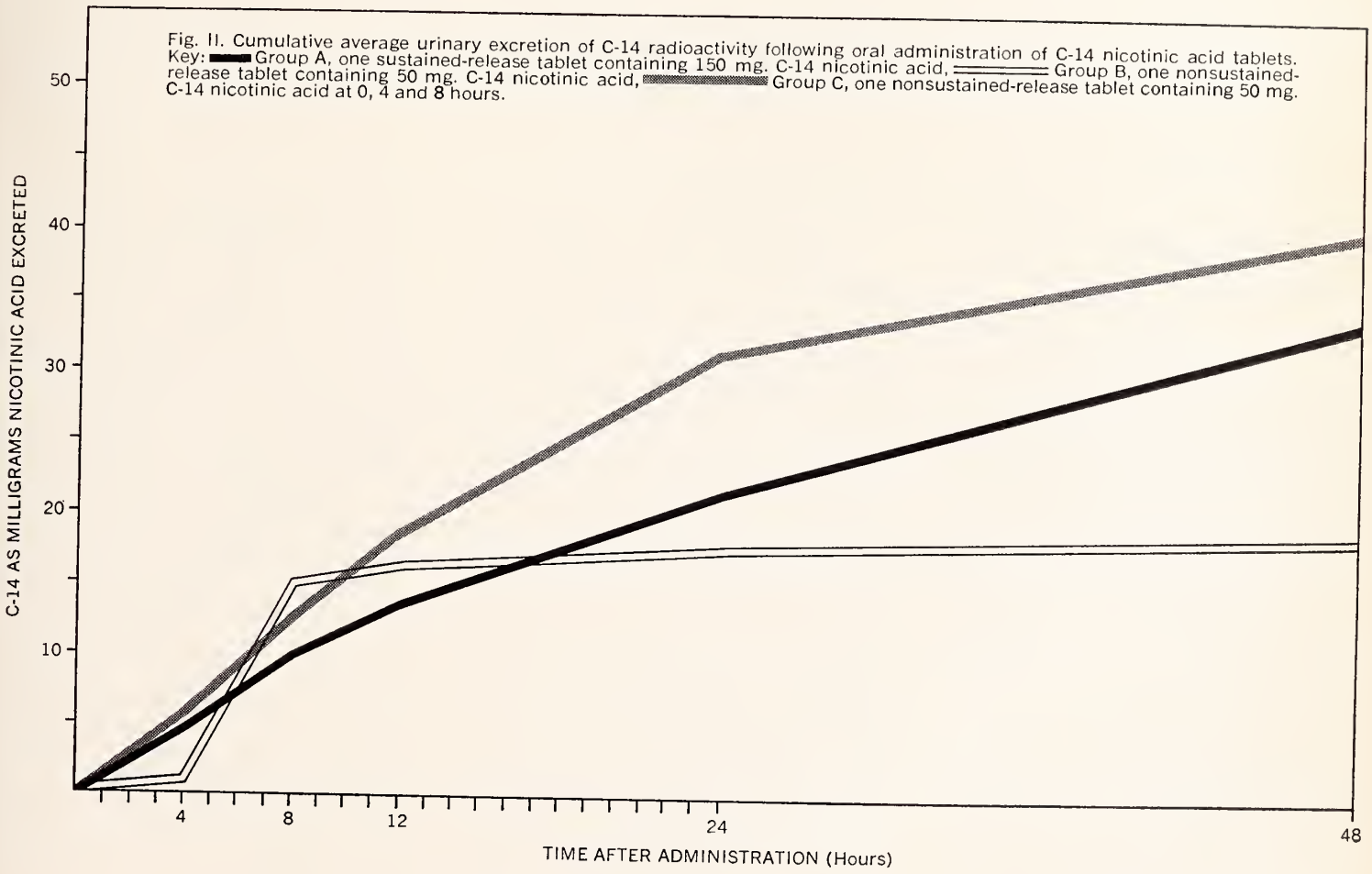

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A prescription for 100 tablets of Geroniazol TT will permit your patients to enjoy the benefits of time-prolonged nicotinic acid/pentylenetetrazol therapy, at an economical price. Dosage is only one tablet every 12 hours.

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References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

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Galactosemia is a serious disease of newborns if it is not recognized. If diagnosed early, it is easily managed and produces no long term effects. Two illustrative case reports are presented. Two laboratory tests, essential to the management, are described in detail.

Galactosemia in the Newborn

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South Bend*

ONE of the causes of jaundice in the newborn is galactosemia. Diagnosed promptly and treated properly, this metabolic defect has an excellent prognosis. To consider the possibility of this disease is the first step in its detection.

The Committee on Fetus and Newborn of the American Academy of Pediatrics has stated, "Every newborn should have a test for reducing substances in the urine on the day of discharge from the hospital."[1] Two cases will be presented to illustrate the necessity of this test.

Case Report No. 1

A male infant, born 2/6/65, weighed 9 lbs., 5 ozs. (4.22 kg.) at birth. He had slight jaundice on the second and third day; the phenylalanine blood level was 2.3 mg%. He was placed on Similac formula which was changed to Sobee Formula at the age of three weeks because of diarrhea. He weighed 9 lbs., 7 ozs. (4.28 kg.) at that time, a gain of only two ounces since birth. He was examined 3/29/65, while he was still taking the Sobee Formula. His weight had increased to 10 lbs., 6 ozs. (4.71 kg.). Because the diarrhea was now under control, he was changed back to Similac and given cereal.

On 4/7/65, the attending physician saw him at home because of frequent brown stools. He was admitted to the hospital that same day at the age of two months because of severe diarrhea with arching of his back. Physical examination revealed a pale infant with a large abdomen. His present weight of 10 lbs., 5 ozs. (4.68 kg.), was only one pound over his birth weight. He appeared acutely ill; his eyes rolling back in his head and his back arched. A lumbar puncture showed 22 white blood cells/cmm, 88% of which were polys. The total protein was 64 mg%, and the spinal fluid reducing substance was 240 mg%. A smear of the spinal fluid was negative. His urine showed 1+ albumin and 4+ reducing substance. The infant appeared moribund at this time.

He was given glucose intravenously, penicillin and streptomycin intramuscularly. During the next 12 hours, he convulsed several times. A true blood glucose of 65 mg% was obtained approximately 12 hours after admission. His urine, which showed 4+ reducing substance on admission, was 3+ the following morning and negative thereafter. There was trypsin present in the stool and a stool culture was negative.

With the combination of high spinal fluid reducing substance, albumin and reducing substance in the urine, and the presence of what apparently were hypoglycemic convulsions, a diagnosis of probable galactosemia was made. Galactose was detected in the urine by paper chromatography the morning after admission. Two days after admission, the measurement of galactose-1-phosphate uridyl transferase activity in the infant's blood was 0 units.

The infant had an uneventful hospital course. He was able to tolerate a meat base formula the day after admission and had no further convulsions. He gained weight rapidly and at the time of discharge, a week after admission, weighed 10 lbs., 12 ozs. (4.88 kg.). Other studies such as calcium, chest x-ray and skull x-ray were normal. He had no cataracts demonstrable in his eyes. He was discharged on a meat base formula, cereal and fruits.

This was the mother's first child by her second husband. She had had four siblings by her first husband, all of whom are normal. The mother's enzyme activity was on the lower limits of normal, being in the possible carrier range. The father showed normal enzymatic activity.

Since discharge from the hospital, the infant has gained weight well. At the age of three months, he weighed 11 lbs., 4 ozs., (5.10 kg.); at four months, 13 lbs., 11 ozs. (6.21 kg.); at five months, 15 lbs., 7 ozs. (7.00 kg.); and at six months, 16 lbs., 13 ozs. (7.63 kg.). He has two teeth. He still has a large abdomen and is mildly irritable, but appears to be physically and mentally normal.

Case Report No. 2

A female infant, born 5/29/65, was type 0 Rh positive for D. The mother was type A Rh positive for D. Glucose water was begun at twelve hours of age

*From the South Bend Clinic and South Bend Medical Foundation.

and breast feeding at 24 hours of age. Jaundice developed at the age of three days. Bilirubin on 6/1/65 was 20 mg%; the CBC was normal and the Coombs' test was negative. The urine showed a trace of albumin and no reducing substance. It was apparent that no blood group incompatibility was present, possibly due to the blood grouping characteristics and the negative Coombs' test. Other causes of jaundice in the newborn were considered. Breast feeding was stopped because of the possibility of the jaundice being due to pregnanediol in the breast milk.[2]

On June 2, the bilirubin rose to 24 and 26 mg%. The urine showed 1+ albumin and 2+ reducing substance. The infant continued to appear well. The next day bilirubins were 27 and 26 mg%. Albumin was 3+ and reducing substance in the urine was 4+. Paper chromatography indicated that the reducing substance was galactose. A meat base formula was begun at the age of four days. The next day the bilirubin rose to 28 mg%, but the urine albumin dropped to 1+ and the reducing substance to 2+. The next day the bilirubin was 30 mg%, the urine albumin was 1+, and the reducing substance was 0. The urine remained negative for albumin and reducing substance thereafter.

Because the bilirubin rose to 30 mg%, a replacement transfusion was performed. Immediately following the replacement, the bilirubin was 11 mg%. The day after, the bilirubin rose to 16 mg%. No bilirubin measurements were obtained after that time; the jaundice subsided rapidly.

The baby's weight was 8 lbs. (3.63 kg.) at birth. This dropped rapidly to 6 lbs., 15 ozs. (3.15 kg.) by the end of the first week. After being started on meat base formula, the infant's weight increased nine ounces (0.26 kg.) in one week's time.

The diagnosis of probable galactosemia was made on June 2, at the age of four days, when the reducing substance was first noted in the urine. No reducing substance was present in the previous day's urine. Paper chromatography confirmed the presence of galactose in the urine and the diagnosis of galactosemia. A request was made for the determination of galactose-1-phosphate uridyl transferase activity in the baby's blood. Before this could be done, the infant's bilirubin rose to 30 mg% and a replacement transfusion was performed. At the time, we did not realize this might confuse our measurement of the enzyme activity.

On June 8, blood samples were taken from the mother, from the infant and from normal controls. The test for gal-1-PUT was made. Our normal control was 3.1 units. The mother was found to have 1.3 units which is approximately half the value of the normal control. This indicated that the mother probably was heterozygous for this particular enzyme. The infant showed a level of 1.5 units. We felt this was due to the replacement blood which had been given a few days before. The infant returned for repeat measurement of the enzyme activity on August 15, 1965, when she was two and one-half months old. At this time, the infant's enzyme level was 0 units.

The infant has been maintained on a meat base formula. Foods which contain no lactose have been added to the diet.[3] The infant is now able to utilize cereals, fruit, vegetables and meat. The last physical examination in October, 1965, at the age of five months was normal. The weight was 14 lbs. (6.35 kg.) compared to a birth weight of 8 lbs. (3.63 kg.).

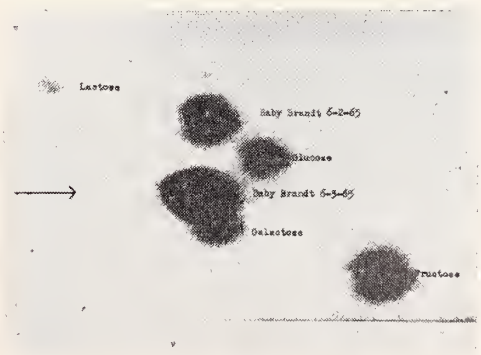

FIGURE 1

A PHOTOGRAPH of a urine chromatography pattern showing the presence of galactose in the urine of one of the galactosemic babies on two successive days. The arrow indicates the direction of migration.

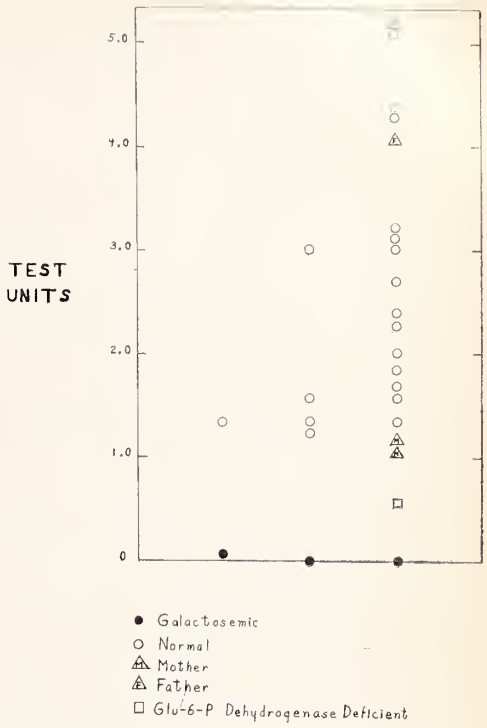

FIGURE 2

A SCATTERGRAM showing the units of galactose-1-phosphate uridyl transferase of three galactosemic babies, parents of two of the babies, one glucose-6-phosphate dehydrogenase deficient adult, and normal controls including newborns and adults.

Comment

The first infant had slight jaundice during the third and fourth days of life. This might have been an indication for performing a test for reducing substance in the urine. This, however, was not done. The infant was not seen by us until he was admitted to the hospital at the age of three months with signs of irritation of the central nervous system and failure to thrive. By this time, once laboratory tests were completed, the diagnosis of galactosemia was fairly obvious. Institution of the proper diet caused an immediate, dramatic change in the infant and his subsequent course has been uneventful and normal.

Having had the experience of seeing this infant in the hospital, we were alerted to the possibility of the disease. When the second case presented itself, immediate studies were made to determine the diagnosis of galactosemia. This was done on the fourth day of life. The second infant has thus been spared the illness and possible death that might have ensued and the parents

the months of worry and frustration had the diagnosis not been promptly made.

The Committee on Fetus and Newborn of the American Academy of Pediatrics has recommended that every newborn have a test for reducing substance in the urine on the day of discharge from the hospital. This should be done on every newborn. The test should be done only after the infant has been exposed to lactose in its diet. The urine on the second infant had no reducing substance on the third day of life. Therefore, it is important that daily urine tests be obtained on newborn infants in whom there is no obvious cause for continuing jaundice. The reducing substance promptly disappears from the urine once the infant is placed on the proper lactose-free diet.

Methods of Detection

The presence of galactose in the urine of a newborn may first be detected in the laboratory with the aid of a routine test for reducing sugars. A bismuth compound such as Galatest (Denver Chem. Mfg. Co.) or a copper containing substance such as Clinitest (Ames Co., Inc.) may be used as a screening test. Such compounds are inexpensive and provide a rapid method for screening purposes while utilizing only a few drops of urine. However, they will not identify the reducing sugar, but only show its presence. Glucose can be identified by use of a glucose oxidase strip test such as Clinistix (Ames Co., Inc.), but this test is specified for glucose and other reducing sugars cannot be identified. Thus, such a test should not be employed where galactosuria is suspected.

A more positive identification of a reducing sugar can be made with simple paper chromatography methods.[4] Our present method utilizes 10 x 45 cm Whatman No. 3 filter paper strips and a descending front technic. The solvent is a mixture of butanol, pyridine, and water in a ratio of 3:2:1.5 respectively.

Approximately 5 lambda of 1% solutions of known reducing sugars that can be found in the urine under abnormal conditions (glucose, galactose, fructose or lactose), along with the same amount of urine containing the reducing sugar, is applied as a spot on a pencil line drawn across the paper strip approximately 12 cm from the upper end of the strip. These spots are dried with the aid of a hot air blower and labeled with a pencil. The upper end is placed in the solvent in the chromatography chamber late in the afternoon and migration is allowed to take place overnight.

The strip is removed from the chamber and dried in a fume hood the next morning. Sugar spot observation is made by spraying the strip with a benzidine solution*, drying, and then heating it in a 100° C. oven for five minutes. The respective sugars appear as dark brown spots and the identification of the unknown urine sugar can be made by comparing its migration distance to that of the known sugars. It has been found to be much more advantageous to place known sugar solutions on the same strip for migration length comparisons than to depend upon identification by use of Rf factors which may vary under changing conditions of time and temperature. A positive galactose spot from the patient's urine indicates a possible galactosemic patient and suggests doing a blood test (Figure 1) for the enzyme galactose-1-phosphate uridyl transferase (gal-1-PUT).

Normally any galactose absorbed into the blood from lactose in the diet is phosphorylated and converted to glucose-1-phosphate by a series of enzyme-activated chemical reactions in which gal-1-PUT is utilized in the final step.[5,6] The glu-1-P is converted to glu-6-P by the enzyme phosphoglucomutase. Glu-6-P may then enter a number of pathways for conversion to energy. One of these pathways is the pentose-phosphate pathway in which reduced triphosphopyridine nucleotide (TPNH) is produced from TPN in the process. In vitro the TPNH formed in these enzymatic reactions is utilized to form TPNH-methemoglobin reductase which will convert methemoglobin back to oxyhemoglobin with methylene blue dye present. The amount of methemoglobin converted to oxyhemoglobin under prescribed conditions of temperature and time is an indication as to the presence or absence of gal-1-PUT.

The semi-micro method described below, a modification of one published by Brewer & Tarlov[7], has been found to be most adaptable for use as a routine test in our laboratory. 0.5 to 1 ml of capillary blood is collected from the baby's heel in heparanized micro blood collecting tubes.** The blood is transferred to a 10 x 75 mm test tube and 0.05 ml of 1.25% sodium nitrite solution (made fresh day of use) is mixed with it to convert the oxyhemoglobin to methemoglobin. After standing for 15 minutes, the blood is centrifuged and the supernatant material removed with care to leave the red cells and the buffy coat intact. The cells are then washed three times with 2 ml of Krebs-Ringer-phosphate buffer solution, pH 7.5*** to remove the excess sodium nitrite and also the residual glucose present. They are then resuspended with an equal volume of the buffer.

0.25 ml of the 50% suspension is added to each of two 10 x 75 mm tubes labeled "control" and "test." Five lambda of 0.05% aqueous methylene blue solution is added to each tube. 0.025 ml of "glucose-free" galactose (Sigma Chem. Co.), 1% in KR buffer solution, is added to the "test" tube and 0.025 ml of KR buffer is added to the "control" tube. The tubes are stoppered and inverted gently several times for mixing and then placed in a 37° C. water bath. At the end of one hour and again at the end of the sixth hour, methemoglobin determinations are made with the use of a Beckman DB spectrophotometer by spectral absorbance technics utilizing 0.025 ml of the mixture.[8] The sixth hour methemoglobin value in terms of grams/100 ml is subtracted from the one hour value. The difference is the amount of methemoglobin converted in five hours. The amount of methemoglobin converted in the "control" tube is subtracted from the amount converted in the "test" tube and this value becomes the "net test value." We have arbitrarily defined a unit as being equal to 1 gm% of methemoglobin converted to oxyhemoglobin under the prescribed conditions of the test.

Of twenty normal control specimens, 19 showed values of 1.2 units or higher (Figure 2). One control gave a value of only 0.6 units, but was later proven to have a deficiency in glucose-6-phosphate dehydrogenase. Although two of the mothers of the three galactosemic infants diagnosed in our laboratories have values at the very low end of normal values, the method is not considered specific for the diagnosis of heterozygous carriers. Other more complex methods are available for genetic studies.[10,11,12]

Summary

Two case reports of infants with galactosemia are presented. They were both born at the same general hospital

*1 gm benzidine; 40 ml acetic acid; 160 ml ethanol.

**Heparinized blood collecting tubes may be obtained from Scientific Products, Evanston, Ill.

***Krebs - Ringer - phosphate buffer, pH 7.5[9]; 100 parts 0.9% sodium chloride; 4 parts 1.15% potassium chloride; 3 parts 1.22% calcium chloride; 1 part 3.82% magnesium sulfate heptahydrate; 20 parts 0.1 M phosphate buffer, pH 7.4. (Prepared with 26.8 gm disodium phosphate heptahydrate and 20 ml I N hydrochloric acid diluted to 1 liter with distilled water.)

within four months of each other. Each presented with jaundice during the newborn period. One was diagnosed at the age of three months; the other was diagnosed at three days.

The value of early diagnosis in infant salvage is obvious. Every newborn should have a test for reducing substance in the urine on the day of discharge from the hospital or during the first week of life after milk has been fed. If the infant becomes jaundiced, repeat tests for reducing substances in the urine should be made.

Two laboratory means of making the diagnosis are presented: 1. An easily performed method for identification of galactose in the urine; 2. A method for the presence or absence of gal-1-PUT in red cells that can be performed in the routine laboratory.

REFERENCES

1. Committee on Fetus and Newborn: Screening of newborn infants for metabolic disease, *Pediatrics* 35:499, 1965.
2. Newman, A. J., Gross, S.: Hyperbilirubinemia in breast-fed infants, *Pediatrics* 32:995, 1963.
3. Hsia, D., O'Flynn, M.: Diet in relation to hereditary metabolic disorders, *Pediat. Clin. N. Amer.* 9:945, 1962.
4. Sophian, L. H., Connolly, V. J.: Chromatographic identification of reducing sugars in urine, *Amer. J. Clin. Path.* 22:41, 1952.
5. Kalckar, H. M., Anderson, E. P., Isselbacher, K. J.: Galactosemia, a congenital defect in nucleotide transferase, *Biochem. Biophys. Acta* 20:262, 1956.
6. Harper, H. A.: *Review of Physiological Chemistry*, 8th ed., Lange Medical Publications, Los Altos, 1961, p. 187.
7. Brewer, G. J., Tarlov, A. R.: A clinical test for galactosemia, *Amer. J. Clin. Path.* 39:579, 1963.
8. Hunter, F. T.: *The Quantitation of Mixtures of Hemoglobin Derivatives by Photoelectric Spectrophotometry*, Charles C Thomas, Springfield, 1951.
9. Umbreit, W. W., Burris, R. H., Stauffer, J. F.: *Manometric techniques*, Burgess, Minneapolis, 1957.
10. Bretthauer, R. K., Hansen, R. G., Donnell, G., Bergren, W. R.: A procedure for detecting carriers of galactosemia, *Proc. Nat. Acad. Sci.* 45:328, 1959.
11. Hsia, D. Y., et al.: Further studies on the heterozygous carrier in galactosemia, *J. Lab. Clin. Med.* 56:368, 1960.
12. Kirkman, H. N., Bynum, E.: Enzymatic evidence of a galactosemic trait in parents of galactosemic children, *Ann. Hum. Genet.* 23:117, 1959. ◄

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From *The Journal* 50 Years Ago

. . . In the United States there are 20,000,000 children in the public schools —15,000,000 have physical defects. Superintendent Hichman of the Plainfield Reformatory states that 70% of the 235 boys in the institution are mentally defective. The conditions present in the care of the insane and defective are such that the death rate is lower than in community in general. Public health work has increased the term of life of defectives. It will fail of its mission unless it concerns itself with the question of the propagation of defectives.

This question of increasing degeneracy can alone be controlled except by a general assent to the requirements of eugenic law; $100,000,000 annually is the price of neglect. Unless preventive measures are put in successful operation to control the increase of defectives, whether it be called eugenics or some less pretentious name, ultimate disintegration of society is more than probable. "Eugenics at present is an assemblage of cold scientific statements *without validity*." It requires the universal demand of the people to breathe into it the spirit of life and galvanize it to action. To the medical profession must be put the question for solution.

As foreshadowed, an additional menace to the country results from the elasticity of the immigration laws, at present presenting a medical farce. America is the dumping ground for the refuse of Europe. "Of the foreign born, the insane claim 15%, more than a normal proportion. One of every 250 immigrants becomes insane and a charge on the public. Our schools are crowded with defectives. In one state of 317 defectives, 277 are of foreign birth." When the senseless war is ended, on the Eastern Continent will come a tidal wave of immigration that will sweep America, and as if to magnify the evil, the great majority will belong to the class rejected by the army as unfit—physically or mentally below the standard of requirement . . . . T. Henry Davis, M.D., Richmond, "The Suppression and Control of Degeneracy," *JISMA*, October, 1916.

The topical use of betamethasone with a new side-chain has produced a large proportion of excellent and good results in common dermatoses, in a relatively short treatment time. A single blind study showed that betamethasone 17-valerate gave significantly better results than flurandrenolone.

Summary of Clinical Experience with a New Ester of Betamethasone—the Valerate (Valisone Ointment)

M. MURRAY NIERMAN, M.D.
Calumet City, Ill.

THIS is one of the first reports published in the United States of a clinical study of the newest and, to date, apparently most effective[1,2] topical corticosteroid developed — the valerate of betamethasone, a long-chain ester at the 17 position of the betamethasone molecule. Use of this new topical agent for treatment of the dermatoses commonly seen in general as well as dermatologic practice has been attended with great success in England, Europe, Canada and South America.[3-7] Betamethasone 17-valerate has been undergoing extensive clinical trials among dermatologists in the United States. This brief report summarizes my clinical experience with the drug in four of its formulations.

Patients and Procedures

In this study of 268 private patients (125 males and 143 females) in dermatologic practice, 94 had eczema; 75 psoriasis; and 46 contact dermatitis. These are, of course, the dermatoses most likely to be seen by the general practitioner and by specialists who encounter dermatologic problems. The patients ranged in age from less than one year to 79 years. About three-fourths of the patients had a chronic disease that had persisted for more than a year.

Betamethasone 17-valerate, in a soft, hydrophilic cream base, was administered to 32 patients in a 0.1% concentration (1.0 mg. per gram) and to 40 in a 0.05% concentration (0.5 mg. per gram). In an ointment base of petrolatum and hydrogenated lanolin, it was administered to 97 patients in a 0.1% concentration and to 99 in a 0.05% concentration. All patients were instructed in the use of the drug, and administered it usually three times a day. Treatment lasted from one week to over three weeks (Figure 1). Occlusive dressings were needed with only 17 patients — a significant advantage, particularly in contact dermatitis, where sweat retention is to be avoided.[8]

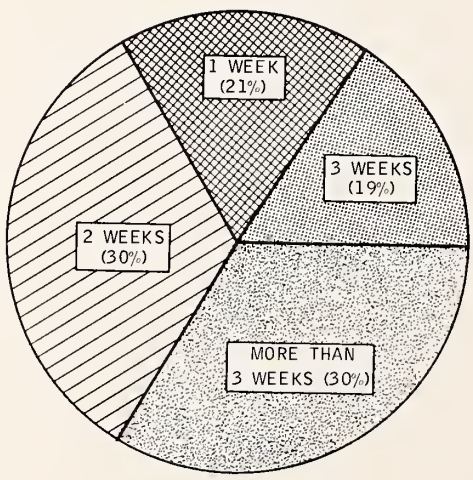

FIGURE 1
DURATION of treatment.

Results

Results were deemed *excellent* when patients with acute disease manifested, within a week, no recognizably active disease process. Chronic eczematous and psoriatic patients were judged to have an excellent result when their disease process was arrested within a week to 10 days and their symptoms brought under control. Intermediate results within these time periods were judged *good* or *fair*, depending upon the degree of disease abatement and symptomatic control. Results were judged *poor* when the patient failed to improve or became worse.

Results in the 268 patients are presented in Table I: 254 patients (95%) showed an excellent response. This is gratifying in view of the large number of patients (199) with a chronic disease. Only one patient failed to improve, the only one who had an adverse reaction. This patient had keratosis folliculare, which was aggravated by application of the 0.05% ointment. At first, I used the ointment with some trepidation because of my past experience with lanolin sensitization, but no sensitization was encountered. The hydrogenation process may account for

RESULTS BY DIAGNOSIS AND FORMULATION

Diagnosis	No. of Patients	0.1% Cream			0.05% Cream			0.1% Ointment			0.05% Ointment		
		E	G	F*	E	G	F	E	G	F	E	G	F
Psoriasis	75	2	0	1	3	1	0	32	1	0	34	0	1
Eczema	94	14	1	0	27	0	0	20	1	0	31	0	0
Contact Dermatitis	46	7	0	0	5	1	0	17	0	0	16	0	0
Seborrheic Dermatitis	6	—	—	—	—	—	—	4	0	0	2	0	0
Nummular Eczema	5	—	—	—	—	—	—	—	—	—	5	0	0
Infected Eczema	4	—	—	—	—	—	—	4	0	0	—	—	—
Alopecia	4	—	—	—	—	—	—	2	1	1	—	—	—
Stasis Dermatitis	2	—	—	—	—	—	—	2	0	0	—	—	—
Pruritus Ani et Vulvae	3	—	—	—	—	—	—	3	0	0	—	—	—
Others**	29	5	1	1	3	0	0	8	1	0	8	0	1
Totals	268	28	2	2	38	2	0	92	4	1	96	0	2

*E — Excellent, G — Good, F — Fair.
**The one poor result was in this category with use of 0.05% ointment. This category includes: Neurodermatitis, rosacea, pityriasis alba, keratosis pilaris, solar dermatitis, prurigo hodgilaris, pustular bacterid, Darier's disease, erythema, and exfoliative dermatitis.

TABLE I

the absence of sensitization with this base.[9,10]

Comparative Studies

In addition to the use studies, a study comparing betamethasone 0.1% ointment with flurandrenolone 0.05% ointment was performed in 65 patients with bilateral, symmetrical lesions. The study was a single blind, that is the patient was given a supply of both drugs and instructed to apply one on lesions on one side of his body and the other on lesions on the other side. Only the patient knew which preparation was used on which side.

When he made his next visit I examined him in the presence of a nurse and evaluated the opposing areas; the nurse recorded my evaluation as well as the patient's opinion of the results. Only then did the patient reveal which side was treated with betamethasone 17-valerate. In many cases, photographs were taken for comparative

RESULTS OF BILATERAL PAIRED COMPARISON IN 40 PATIENTS WITH ECZEMA

Betamethasone 17-Valerate Better	Results Equal	Flurandrenolone Better
12	21	7

RESULTS OF BILATERAL PAIRED COMPARISON IN 25 PATIENTS WITH PSORIASIS

Betamethasone 17-Valerate Better	Results Equal	Flurandrenolone Better
19	6	0

TABLE II

study. Of the 65 patients thus studied, 40 had eczema and 25 psoriasis. The evaluated results, presented in Table II, show betamethasone 17-valerate decidedly better in both categories of patients and strikingly so in patients with psoriasis.

The comparative efficacy of betamethasone 17-valerate is also indicated by my general observations of the patients' responses to "switching" from flurandrenolone or fluocinolone acetonide to betamethasone 17-valerate and then back again. This is the only comparative method available when there are no bilateral, symmetrical lesions. This method was used in many cases of chronic skin disease, particularly where the corticosteroid was being used as a suppressor of inflammatory activity. The degree of suppression could be seen to vacillate in many instances as the ointments were switched. Patients whose lesions were at a standstill showed marked improvement when they switched to betamethasone 17-valerate from another corticosteroid. Often, when they switched back to the other corticosteroid, their lesions worsened.

Discussion

Two questions naturally arise: When should the 0.1% concentration be used in preference to the 0.05%, and when should the ointment be used in preference to the cream?

Although the 0.05% ointment appears to be about as effective as the 0.1% ointment, the 0.1% concentration probably should be used in beginning treatment of severe dermatoses and when a rapid response is desired in less severe dermatoses. The 0.05% concentration probably should be reserved for long-term maintenance treatment of severe, chronic dermatoses, particularly those involving large areas of the body, after symptomatic control has been achieved with the 0.1% concentration. When occlusive dressings are needed, the "half-strength" 0.05% concentration is, of course, preferable, because the increased hydration induced by occlusion appears to enhance percutaneous absorption of corticosteroids.[11]

In general, the ointment is preferable to the cream, particularly in treatment of the dry, scaly lesions of psoriasis. In fact, the ointment, without occlusive dressing, had a better effect in psoriasis than any other preparation I have ever used, even with occlusive dressing. Furthermore, in a limited paired-comparison study I made in 10 patients with eczema, the sides treated with betamethasone 0.1% ointment showed better results in eight of the patients than the sides treated with betamethasone 0.1% cream. In the other two patients, results were about equal.

Acknowledgment

Dr. Roger W. Cooper, Clinical Investigation Division, Schering Corporation, Bloomfield, New Jersey, supplied the betamethasone 17-valerate cream and ointment used in this study.

BIBLIOGRAPHY

1. McKenzie, A. W., Atkinson, R. M.: Topical activities of betamethasone esters in man, *Arch. Derm.* (Chicago) 89:741, (May), 1964.
2. Stoughton, R. B.: Topical steroids, *Mod. Treatm.* 2:841, (Sept.), 1965.
3. Williams, D. I., et al.: Betamethasone 17-valerate: a new topical corticosteroid, *Lancet* 1:1177, 1964.
4. Bjornberg, A., Hellgren, L.: Betamethasone 17-valerate for topical treatment in psoriasis and eczema, *Acta Dermatovener.* (Stockholm) 44:333, 1964.
5. Wrong, N. M.: *Current News in Dermatology*, No. 26, (Nov.), 1964.
6. Cordero, A. A.: Betamethasone valerate, a new corticosteroid for topical dermatologic use, *Prensa Med. Argent.* 52:1365, 1965.
7. Kaminsky, A., et al.: New observations on betamethasone valerate, *Prensa universitaria*, 99:1612, 1964.
8. Scholtz, J. R., Nelson, D. H.: Some quantitative factors in topical corticosteriod therapy, *Clin. Pharmacol. Ther.* 6:498, (July-Aug.), 1965.
9. Barnett, G.: Lanolin derivatives and modifications, Part 1, *Drug Cosmet. Industr.* 80:610-612, 699-703, (May), 1957; Part 2, ibid. 80:744-745, 845-853, (June), 1957; Supplementary review, ibid. 83:292-295, 368, 372, (Sept), 1958.
10. Fayaud, A.: Hydrogenated lanolin, *American Perfumer & Aromatics* 68:48, (Oct.), 1958.
11. Stoughton, R. B.: Percutaneous absorption: Influence of temperature and hydration, *Arch. Environ. Health* (Chicago) 11:551, (Oct.), 1965. ◄

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Apologia

The name of Dr. Jerome Doss, 3520 S. Lafountain, Kokomo, was inadvertently omitted from the 1966 edition of The Roster.

Dr. Doss has been a member of the Indiana State Medical Association for several years. We regret any embarrassment or inconvenience caused by this error.

The Case of the Carnal Congenital Cardiac

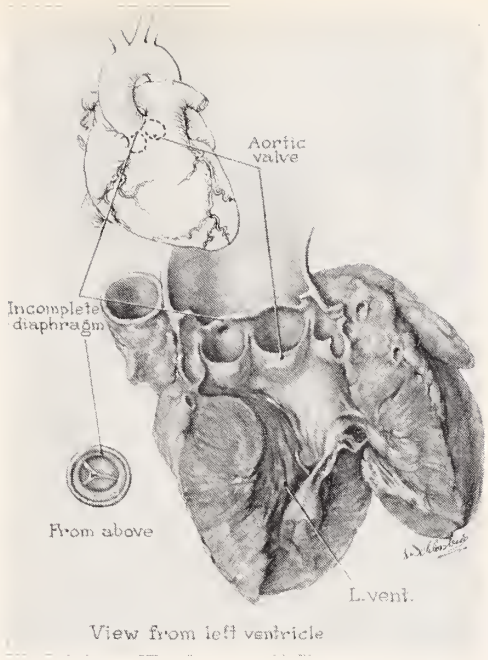
ARNOLD LIEBERMAN, M.D.
New York, N. Y.

FAY FOYL is a continuing challenge to the physicians at the municipal hospital of one constituent borough comprising the megalopolis we call New York. In addition to the doctors, the sociologists have also come to know her only too well: the medical and the ancillary social questions have baffled us all.*

The history was a tangled skein that took years to unravel. Admittedly, neither Fay nor her mother are very bright; however, we did not always ask the right questions. Her father had dropped dead at 42; he was known to have had "heart noises." Fay's mother had been pregnant some dozen times; only Fay and a younger sister had survived past infancy. When Fay entered school, the examining doctor told the mother that the child had "a very bad heart." The subject appears to have been dropped as nothing further was done. Fay was an exceedingly bad student and a most serious disciplinary problem in more ways than one (See "The Case of the Juvenile Jetsam," *JISMA* 53:1493, Aug., 1960). She was a "drop-out" at the earliest possible age. Actually, she is an illiterate who can just manage to sign her name. The Mississippi teachers *AND* the juvenile officer were happy to see her move with her family up North.

* While the medical precis is painstakingly accurate, all resemblance to living persons has to be assumed as being strictly coincidental.

Cut depicting supravalvar aortic stenosis furnished by Dr. Victor McKusick, M.D., Professor of Medicine, Johns Hopkins Hospital.



Cardiac Caveat

At age 13, she first entered the hospital on whose wards she was to build up the hefty folder to which I'm now referring. In the emergency room, note was made of the profuse vaginal discharge. Oh, yes! The mundane gonorrhea had been acquired in the usual, most prosaic way. However, she had spiked a very high fever. Cardiac murmurs were recorded as "rheumatic heart disease? — G.C. to be ruled out." Repeated blood cultures yielded streptococcus viridans on three successive occasions. This made the diagnosis of subacute bacterial endocarditis mandatory. The resident's diagnosis was "rheumatic fever produced aortic stenosis."

Still, there was nothing in the history to suggest antecedent streptococcal disease. On rounds, I had a brain storm, and suggested "Why don't you have the mother and the sister come in?" To me, the stenosis seemed so severe that I began to consider the possibility of a *congenital* affair. Sure enough! The seven-year-old sister had a murmur identical with Fay's. . . . The mother's cardiac status was quite within normal limits. It was at this time that we extracted the significant history of the father having dropped dead: a common exitus for persons having severe aortic stenosis.

The 50,000,000 units of daily I.V. penicillin plus all the supplementary maneuvers cleared the g.c. and suppressed the SBE,* flattening the fever spikes rather promptly. They did nothing for the diamond-shaped murmur so typical of aortic stenosis.

The strict regimen was maintained for four weeks. Then the medications were tapered off. She was kept on the ward for a full two months to forestall any possible recidivism that is so characteristic of SBE. To be candid, we also desired to keep the young lady until such time as cardiac catheterization studies would be safe. After all, the diagnosis of "just" congenital aortic stenosis is not sufficient. Of course, the typical, prolonged, loud and low pitched, diamond-shaped ejection murmur just could not be anything else. It extended up into the neck vessels and was associated with a tremendous, almost visible thrill. The heart was beginning its inexorable enlargement and the EKG showed the expected beginning left ventricular overload.

BUT — was the defect *at* the valve, *below* the valve or *above* the valve?? These varieties have been studied in some detail and the relevant, recent literature is already quite extensive and proliferating prodigiously. Nadas' *Pediatric Cardiology* has a very com-

*When I had my first sight of Fay, the day after her admission, she must have been ill for quite some time. She had the full-blown, classical signs of SBE: 1) Janeway spots on the palms and soles: 2) Osler nodes, the tender nodules at the finger tips and toes; 3) even the Roth spots in the ocular fundi (round hemorrhages with the white center). She had severe left upper quadrant pain; the spleen could be percussed even if not actually palpated. There was no record of renal hematuria. There was a severe secondary anemia, a 25,000 white count and an enormous sedimentation rate. Besides the I.V. penicillin, she received it in I.M. doses of 600,000 units q. four hours. Also, probenecid, 0.5 gm. q.i.d. and streptomycin 0.25 gm. I.M. b.i.d. were not forgotten.

plete discussion. The sub-valvular — "hypertrophic obstructive cardiomyopathy" — version is the subject of an exhaustive Ciba Symposium (See review in *JISMA*, 58:1278, Nov., 1965). The supravalvar variant is less well-known. Its precise delineation requires meticulous use of such technics as cineradiography, B.P.'s with positioned cardiac catheters every inch of the way, etc., etc.*

The best laid plans of mice and men "gang aft a-gley." Just when we began to press Fay Foyl to have the studies done — the gal up and went home. She was feeling fine and all this high-falutin talk about possible dangers of letting the aortic stenosis go to its inevitable exitus was just so much mish-mash to our ignorant patient and her totally illiterate mother.

*1. McKusick, Victor: Conner Lecture on Genetic View of Cardiovascular Disease, *Circulation* 30:326-357, Sept., 1964.

2. Taussig, Helen, Sissman, N. J.: Congenital Aortic Stenosis, *Circulation* 19:458, 1959.

3. Markovskaia, G. I., et al.: Experimental Cardiac Lesions, (in Russian), *Kardiologiya* Sept.-Oct., 1965, pp. 8-13.

4. Logan, W. F. W. We, Jones, E. W., Walker, E., Coulshed, N., Epstein, E. J.: Familial Supravalvar Aortic Stenosis, *Brit. Heart J.* 27:547-559, July, 1965. A very detailed analysis of supravalvar aortic stenosis with a presentation of a family with *three* generations having the condition. There is presentation of some cases having characteristic facies, blue irises, tortuous retinal vessels, mental retardation and an abnormal chromosomal mosaicism with an extra group 19-20 chromosome. Still other cases have, during infancy, a very high grade of hypercalcemia with its attendant complications . . . .

5. Petry, Eugene L., Lurie, Paul R.: Supravalvar Aortic Stenosis and its Correlates, *Heart Bull.* 14: 97-100, Sept.-Oct., 1965.

A very precise (and concise), lucidly written and beautifully illustrated presentation. Attention is again drawn to the combination of the infantile hypercalcemia and the "elfin facies" also seen in the mentally retarded cardiacs. Attention is also called to the accompanying *pulmonary* artery narrowing often seen as a correlate . . . . This last comes from the Indiana University School of Medicine. Dr. A. Donald Merritt, Chairman of the Department of Medical Genetics, had the kindness of briefing me personally on the research that is opening some truly exotic vista . . . .

A Sybaritic Sylphid

Then began a sequence of events that would be comic were it not fraught with ever graver overtones. That very fall, the now 14-year-old Fay came in with a four month miscarriage! The following spring: same patient, same condition, same result! Fay is an excellent illustration of extreme eroticism (See "The Case of Veneniferous Venery," *JISMA* 56:51, Jan., 1963). Unabashedly, she flaunted her preference for "strong men!" It seems she did not even spurn women. Her mother may not have participated in the "parties" — certainly, she did nothing to discourage the shenanigans.

Oh, yes! The mother and her two daughters were on welfare. The tax-supported bacchantes had ample time for revels — orgiastic or otherwise. . . .

It was spring of 1964 before Fay was finally inveigled (between pregnancies) into the hospital for the cardiac catheterization studies; by now, she was 22 years old. She still had nary a symptom; she felt "perfectly fine." Mirabile dictu, she was free of any venereal disease. Blood pressure in the arms was 100/80; pulsus tardus was obvious. The apical systolic murmur was an intense gallop. With her mouth open, I could hear it with my ear several inches away from the suprasternal notch. Twice in my life, I've had the privilege of hearing the plucked harp-like twang of an aberrant chorda tendinae: this is the only cardiac sound that I know is even louder: it can be heard at a distance of several *FEET!* Fay's early diastolic decrescendo murmur over Erb's point is the loudest I've ever heard over that particular spot. There was *no* ejection click. The EKG had worsened (Figure 1). Concordant left ventricular hypertrophy is vividly apparent. The x-ray of the chest (Figure 2) showed the left ventricle almost filling the entire left side of the chest well out to the auxiliary wall.

The actual catheterization studies were even more ominous than the routine, preliminary maneuvers (Figure 3). Unfortunately, only the arterial work could be done at the one sitting. The orifices of the coronaries were dilated and tortuous. Cineradiography showed that, less than 0.5 cm. above the coronary ostia, the lumen of the aorta narrowed to a slit of no more than 3 mm. in cross section. Putting this another way: only some 5% of the normal opening remained patent!! *WHY* was Fay symptom free? How wrong can we doctors be?? (Read: Simonson, Ernst, Lieberman, A.L.: Russian Research on Cardiac Compensation and Decompensation, *Am. Heart J.* 65:687-696, May, 1963).

Let us not belabor the point! Fay was feeling "just fine;" she refused to permit the venous studies. What nonsense was this? Fay went home; we did not learn as to whether there was or was not any pulmonary artery disease.

On 3/2/65, I saw Fay the next time. Yes, pregnant since Oct., 1964. I quote from my entry into her folder that day, "advise, yet again, to consider eventual surgery for the correction of the cardiac defect." Fay's chit-chat was disarming in its candor, "But, Dr. L.! My Johns and Janes PAY me to have fun! And I *never* take drugs or liquor or anything like that . . . ." It was perfectly true that the CONGENIAL CARNAL CARDIAC knew one outlet and one outlet only: the gamy gamut of sex.

Philoprogenitive Parent

This time, Fay Foyl finally carried the pregnancy to term. The baby was duly delivered that summer even if it was touch and go for a while. The excited resident called me anent the event. He bubbled, "Guess what! The infant has a cardiac murmur exactly like mamma and aunty!"

Fay has now become a more regular visitor to our OPD clinics. She brings the baby that she seems to cherish. Rather grudgingly, she is an occasional visitor to our cardiac clinic. Her growing sister has also been studied quite thoroughly; her congenital defect is identical to Fay's. The entire menage is still on welfare; Fay has ample time still for her amours. Inexplicably, she

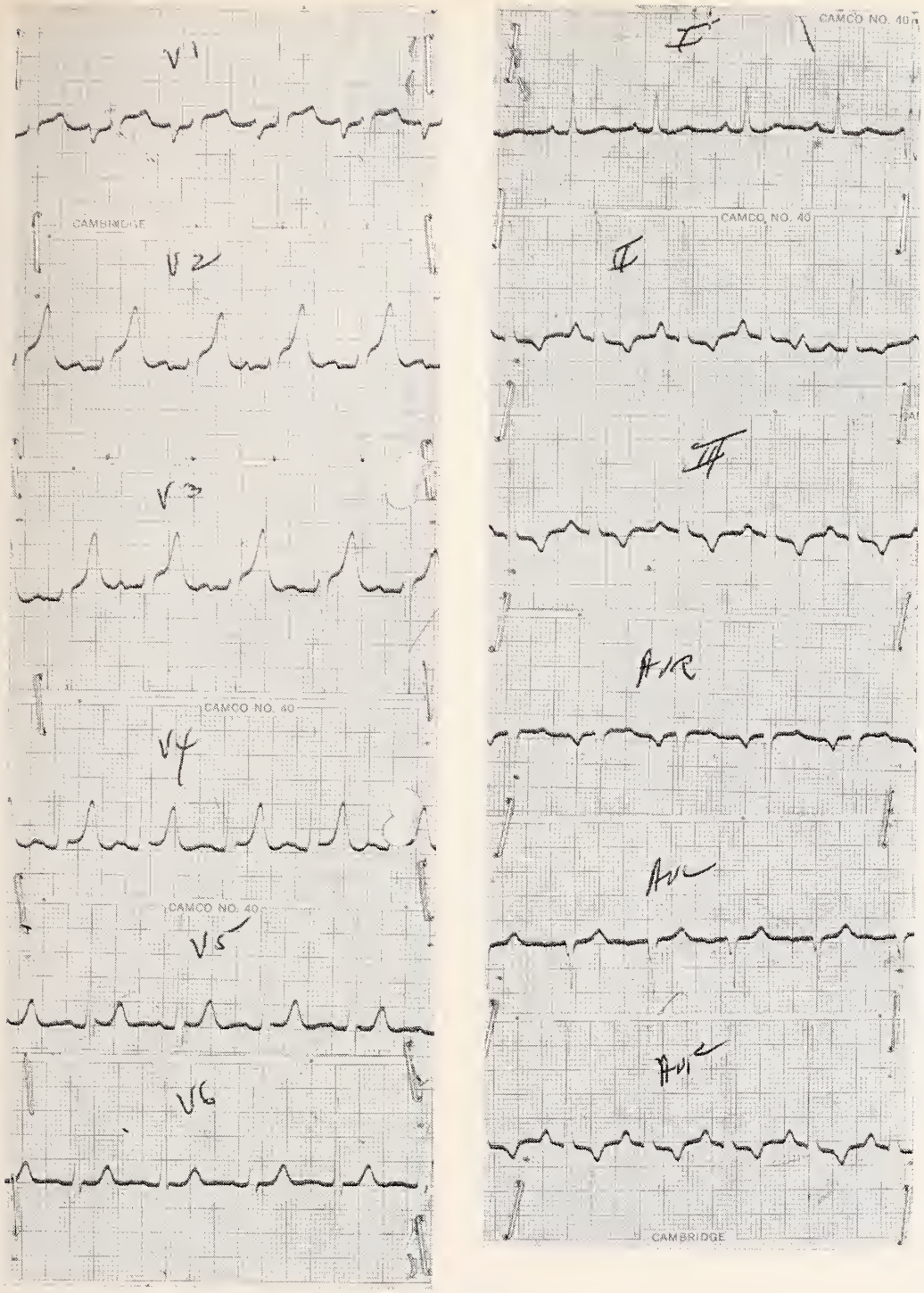


FIGURE 1
ELECTROCARDIOGRAM showing the concordant left ventricular hypertrophy.

FIGURE 2
X-RAY shows the left ventricle filling almost the entire left side of the chest.

FIGURE 3
CATHERIZATION studies showed: LA—Blood pressure 96/84. LV—254/0/16/32; LV repeat —276/0/20/32; aorta proximal to coronary arteries—242/60; aorta distal to coronary arteries—130/60. Left arm by cuff—100/90.

still feels fine; she cannot comprehend all the fussing by the baffled medicos.

The purely medical aspects of the case have been already outlined.*

*Dr. Victor McKusick has been especially helpful in his personal comments besides furnishing the cut of the figure taken from his Conner lecture. In addition, one could look on p. 735 of Edwards & Carey's atlas on *Congenital Heart Disease* (2 vol.; Saunders & Co., 1965).

In this case capsule, we are actually reporting either the third or fourth instance of a three generation inherited, congenital, supravalvar stenosis. It seems to be of the dominant type even if we did not demonstrate pulmonic stenosis or microcephaly. Just like her father, Fay's chances of a sudden exitus are looming in the background as an ever-increasing menace. The heart just cannot go on and on enlarging, concentrically and excentrically, ad infinitum. If the clinical and laboratory parameters have any significance whatever, the utmost limits of the possible have already been attained.

Fay is now of the age of consent. if we could get through to her low I.Q. comprehension — can we be still so emphatic about urging surgery?? The most favorable time for appropriate operative correction has been left in the receding past. She has *NO* cardiac reserve — never mind the absence of symptoms that passes our col-

lective understanding. The surgeon would not be performing a trifling bit of carpentry. An already overstrained myocardium just could go into permanent cardiac arrest even while Fay was being anesthesized and before the bypass could be set up. If there is a "mere" malrotation with severe subintimal fibrosis, then relatively simple tenotomy might suffice. Because of our belief that this is the likely genetic error, our hope is that such surgery would prove sufficient: always assuming that she could survive the risks inherent to her precarious state.

BUT — just supposing that the atresia is of the atrophic type? Then, the surgeon can enlarge the aortic tube only by the device of a Teflon graft. Will there be room for the cuff *not* to encroach upon the coronary ostia? What would the operator do when driven into such an ineluctable cul-de-sac? Provided, i.e., that the patient on the table was still breathing . . . .

Now as to the social problems: neither Fay nor her mother asked to be born. Society has the immense responsibility of caring for her and her baby while they are in this world. Have we doctors the moral right of insisting that Fay be sterilized? Frankly, at this stage, I cry, "mea culpa." I now agree with the Ob—GYN Board that refused me on this point one-half dozen years back. And: what will happen to Fay's baby when (and if) it grows up?

As of this writing, everything is at loose ends. Some day, we may be able to wrap up neatly: a clinicopathological conference does just that. If I haven't had my definitive coronary before that event — why, I'll let you know! ◄

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About Our Cover

Fall in Indiana . . . covered bridges . . . the end of ISMA District Meetings . . . raking leaves . . . getting out the flannel nighties and moth balls . . . raking leaves . . . ISMA Convention over . . . new committees and commissions forming and making plans for the new year . . . raking leaves . . . getting ready for the AMA Clinical Convention next month . . . planning for the State Legislature . . . getting out the vote for the Congressional elections . . . traveling to Brown County to see the beautiful color . . . sitting in line for hours to get into the park . . . wishing you had painted the house last summer . . . cider and doughnuts . . . Halloween . . . trick or treaters . . . weiner roasts . . . hayrides . . . horseback riding . . . cold and flu season starts . . . football games . . . chrysanthemum time . . . mothers getting bored after the first flush of victory wears off in getting the children "back to school" . . . storing the lawn furniture . . . getting the rose bushes ready for winter . . . pumpkin pie with whipped cream . . . for you eager beavers addressing your Christmas cards, relax! . . . a hint from Heloise: use kerosene and newspapers to clean those storm windows before installing . . . fire in the fireplace . . . anti-freeze in the car . . . clean the furnace and get new filters . . . relaxing in a warm house and reminiscing . . . no more grass to cut.—J.F.S.

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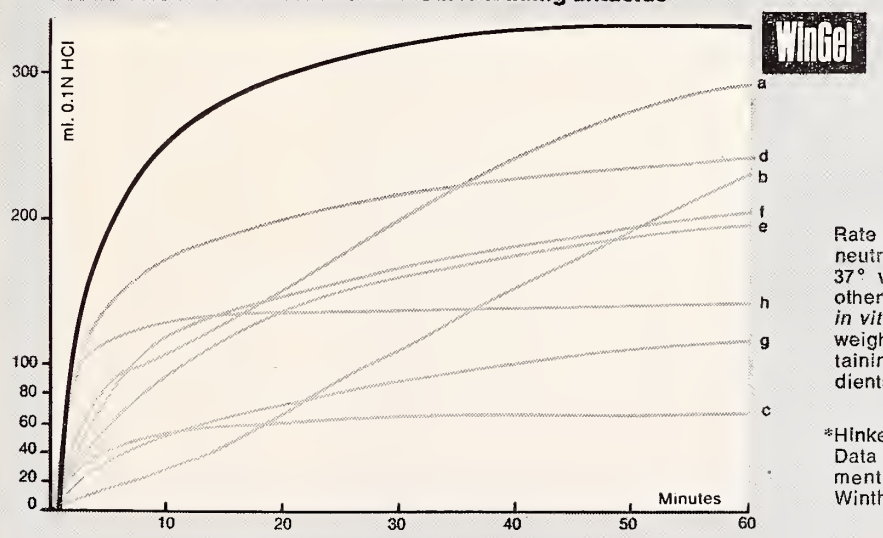

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*Hinkel, E. T., Jr. (New York): Data in the files of the Department of Medical Research, Winthrop Laboratories.

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(1058M)

X-RAY CONFERENCE

Presented as a regular feature of *The Journal*, X-ray Conference is a series of short talks on procedure and radiologic diagnosis, edited by Erich K. Lang, M.D.

Congenital Lipoma of the Spinal Canal Associated with Lumbar Dysplasia

*ERICH K. LANG, M.D.**
Indianapolis

A six-year-old white female was admitted to the hospital with a history of progressive weakness in the lower extremities. After birth, the patient had been subjected to a spinal operation; the transcripts of this hospitalization were not available for perusal. She had been relatively asymptomatic since then, however during the past two weeks, the patient regressed to crawling and seemed unable to bear her weight.

Neurologic examination revealed the cranial nerves to be intact. A well-healed laminectomy wound was seen over the lower lumbar area. Motor function of all extremities appeared to be intact. A vague area of hypalgesia and hypesthesia over the sacral region, the saddle area, as well as the buttocks, was ascertained. The reflexes were increased at the ankle. An ankle clonus and positive Babinski were present. Lumbar spine films revealed laminectomy defects extending from D-12 through L-4. There was also evidence of congenital hypoplasia of the neural arches on the left side at the level of L-1, L-2 and L-3. Whether this was associated with the operative procedure performed at birth or whether it represents an independent anomaly could not be ascertained.

A myelogram was performed after 1ccs. of pantopaque had been introduced into the cisterna magna (Figure 1). Nodular filling defects were readily demonstrated in the area of the lumbar canal. The appearance simulated giant pearl-string like filling defects such as one would expect to see with huge varices of the esophagus on a barium swallow roentgenogram. The associated deformity of the neural arches on the left side and the apparent widening of the lumbar canal suggested the presence of neurolipomas or lipomas of the lumbar canal. On exploration, the cord was found to be adherent and the canal was studded with recurrent congenital lipomas of the conus medullaris. It was thought that most of her symptoms might be on the basis of a traction phenomena. Most of the lipomatous tissue was hence removed, and the cord freed.

FIGURE 1
THE lumbar myelogram performed following introduction of dye into the cisterna magna, outlines multiple round and irregular shaped pearl-string like filling defects in the lumbar canal. The appearance suggests the presence of multiple masses, most likely lipomas or neurolipomas. Arachnoidal cysts may present in a like fashion. The defects of the neural arches are partially congenital and partially due to the original surgical procedure.

The patient improved temporarily, but thereafter her condition deteriorated and finally progressed to paraplegia. Severe urinary retention resulted and an indwelling catheter had to be anchored.

Discussion

The myelographic appearance of multiple filling defects arranged in a pearl-string like fashion in the lumbar canal is somewhat unusual. Lipomatosis of the canal is frequently seen in the sacral area and is associated with

*Radiologist, Methodist Hospital, Indianapolis.

diastematomyelia. In the lumbar canal, this is less frequently seen. In this case, the changes were most likely caused by residual lipomas displaced cephalid by the original surgical procedure. The fixation of the cord at a slightly higher level is probably also a sequela of the surgical procedure. The classical midline bone spicules could not be demonstrated. This, however, is only seen in diastematomyelia not previously treated.

ASTHMA: IMMUNOLOGICAL AND NON-IMMUNOLOGICAL

One of a series of case reports illustrating the differential diagnosis in patients with symptoms of asthma.

IRVIN CAPLIN, M.D.
JOHN T. HAYNES, M.D.
Indianapolis

A 42-year-old woman was first seen in March of 1962. She had been treated for severe asthma in El Paso, Texas since 1953. She had had hay fever and asthma since childhood; the hay fever occurred in the grass and ragweed seasons of the year. She was treated in Texas with a mixture of dust, molds, ragweed and grass pollen. In 1957, she developed a severe infectious process with hemoptysis. An x-ray at that time revealed an infiltration of the right upper lobe with honey-combing throughout both lung fields. The radiologist made a diagnosis of active tuberculosis, but tuberculin testing and sputum examinations were negative. Guinea pig inoculations were also negative for acid fast bacilli. Testing to coccidioidin and histoplasmin were negative. Follow-up x-rays revealed a gradual clearing of this process.

In September of 1961, a pneumonic process again occurred and a diagnosis of staphylococcic pneumonia was made. Sputum became bloody and purulent. She was treated with T.A.O., did well and was asymptomatic 30 days later.

This patient's treatment with dust, molds and pollens was continued. She did well until October, 1964, when she again developed fever, hemoptysis, and a purulent sputum. The W.B.C. revealed 18% eosinophils. A chest x-ray (Figure 1A) revealed extensive changes in both lungs with a massive lesion in the left upper lung field. Again the radiologist felt that there was an acid fast infection or a staphylococcic pneumonia. The patient was treated with Panalba and over a period of three weeks became asymptomatic. A chest x-ray taken three weeks later revealed (Figure 1B) almost complete clearing of the massive lesions in her chest.

This patient is felt to represent a recurrent Loeffler's syndrome. The bizarre infiltrations which are found

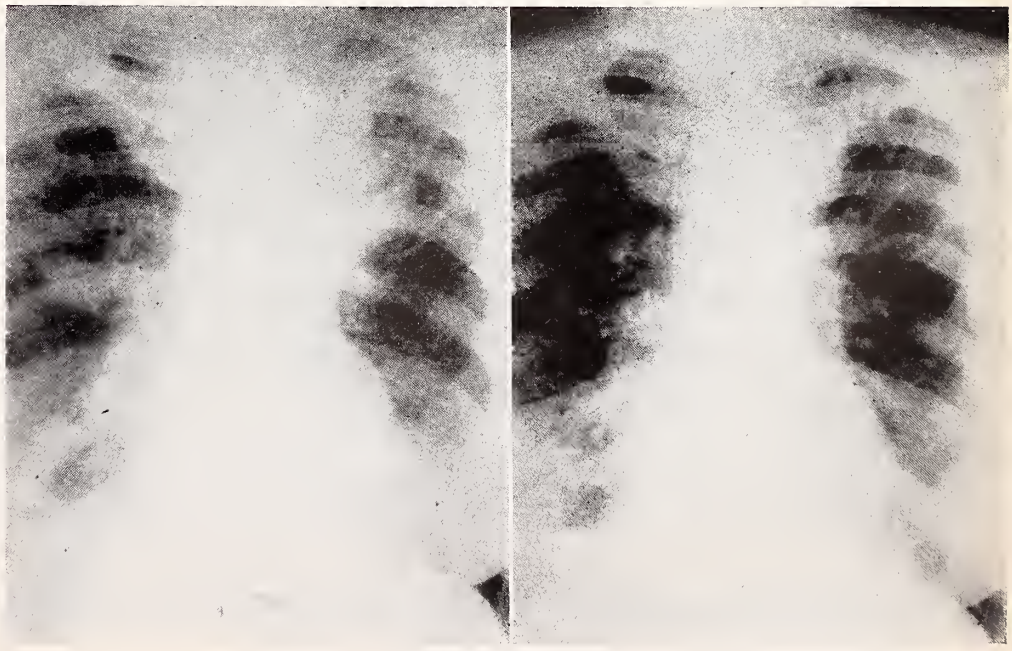

FIGURE 1A AND B
LOEFFLER'S syndrome infiltration in the left upper, right middle and right lower lung fields is evident in 1A. Three weeks later (1B), almost complete clearing is noted.

first in one portion of the lung and then in another, and their rapid clearing, are characteristic of Loeffler's syndrome which is frequently seen as a complication of asthma.

Case Report No. 2

A 34-year-old woman was first seen in August, 1961, with a history of asthma of 14 years duration. She knew that she was aggravated by house dust and ragweed, but had long periods of freedom between attacks. Physical examination revealed moderate asthma. Skin tests revealed positive intradermal tests to dog hair, feathers, wool, cattle hair, kapok, ragweed, and several molds.

A chest x-ray (Figure 2A) revealed an infiltration in the left upper lung field, which was felt to represent a possible acid fast infection. Tuberculin tests, sputum smears, and cultures for acid fast bacilli were negative. Histoplasmin and coccidioidin tests were also negative. Re-x-ray (Figure 2B) of the chest six weeks later revealed complete clearing of the density in the left upper lung field. It is difficult to define the nature of this lesion which may be part of the obstruction caused by asthma. It is possible also that this may be a variant of the type of infiltration one sees in patients with Loeffler's syndrome.

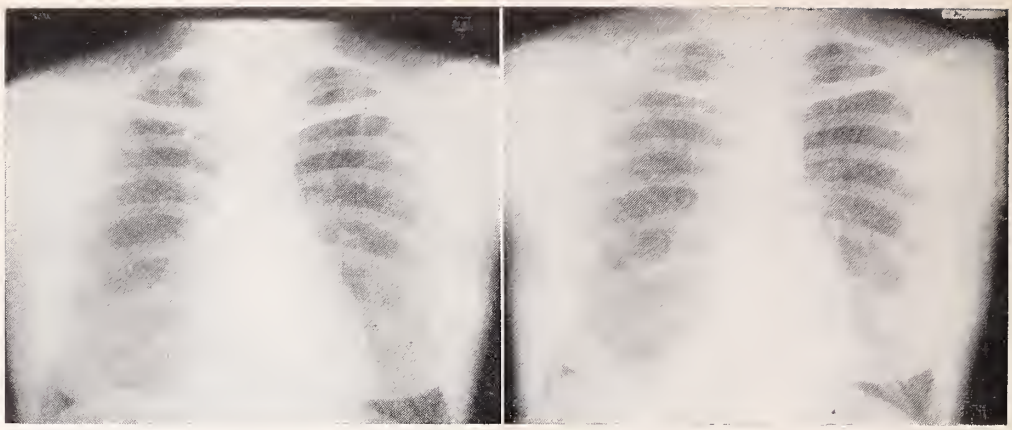

FIGURE 2A and B
A soft infiltration is seen beneath the left clavicle in Figure 2A. Six weeks later (2B), there is complete clearing of the infiltration.

Case Report No. 3

A 22-year-old woman who had been treated for severe asthma since early childhood with a mixture of dust, ragweed and grasses, suddenly developed fever, a productive cough and hemoptysis. Her asthma became much worse. She was treated with T.A.O. and steroids to control her asthma.

A chest x-ray revealed a diffuse infiltration in the left upper lung field (Figure 3A). Tuberculin, coccidioidin and histoplasmin skin tests were negative. Sputum examinations for acid fast bacilli were negative on smear and culture. Figures 3B and 3C reveal a gradual resolution of this diffuse inflammatory process. Again, we have a diffuse inflammatory process of unknown etiology which cleared remarkably well, and one again wonders if this might not be a variant of Loeffler's syndrome.

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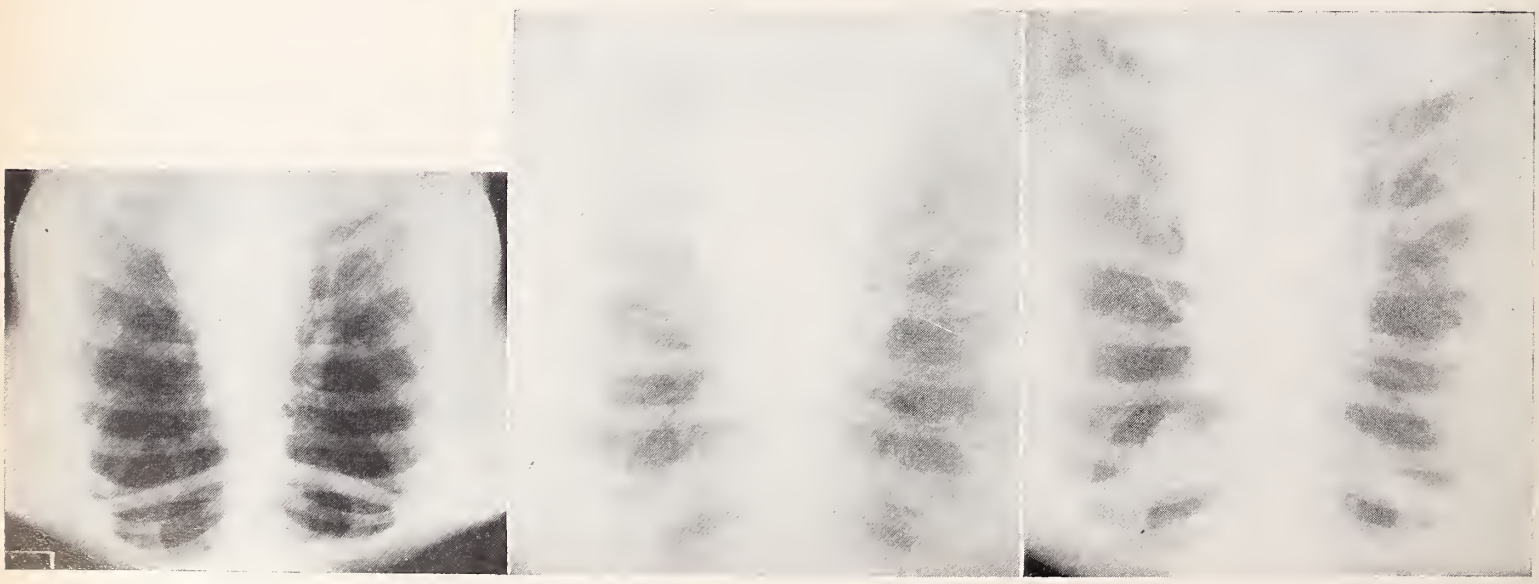

FIGURE 3A, B and C
DIFFUSE infiltration in the left upper lobe, cause undetermined, is evident in Figure 3A. Four months later (3B), there is almost complete resolution and six months later (3C), complete resolution.

Now, now, Mrs. Forsythe, we've never lost a cold patient yet.

When she's experiencing acute discomfort from cold symptoms, it's small wonder the patient becomes distressed about her condition.

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Use cautiously in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution patients who operate machinery or motor vehicles that drowsiness may result.

Each Novahistine LP tablet contains: phenylephrine hydrochloride, 25 mg., and chlorpheniramine maleate, 4 mg.

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NOVAHISTINE® LP

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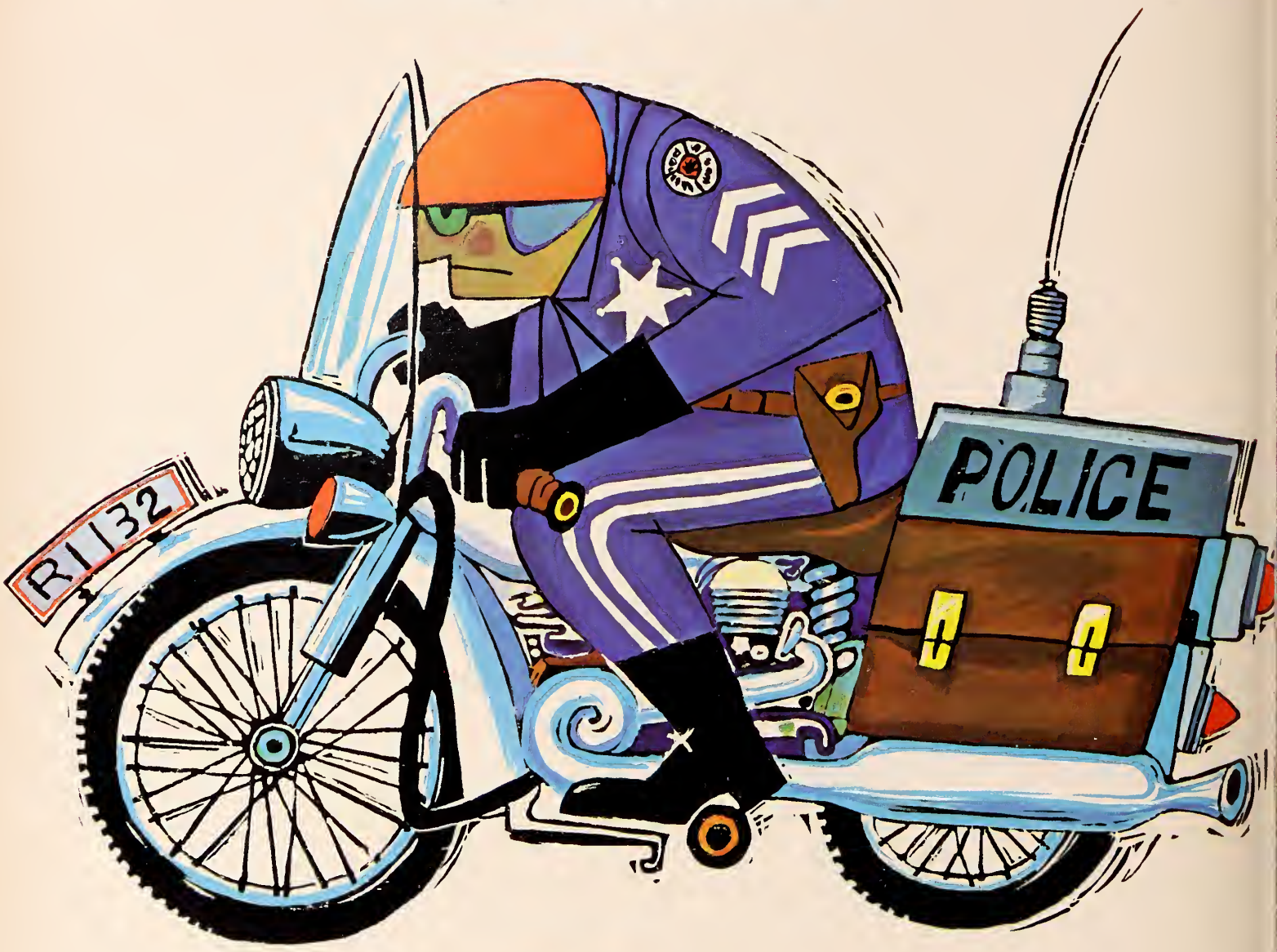

LOMOTIL®

Each tablet and each 5 cc. of liquid contains:
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- **Ileostomy**
- **Gastroenteritis and colitis**

Dosage: For correct therapeutic effect—Rx correct therapeutic dosage. The recommended initial daily dosages, given in divided doses, until diarrhea is controlled, are:

Children: Age	Total Daily Lomotil Dosage	Lomotil Liquid Dosage (Each teaspoonful [4 cc.] contains 2 mg. of diphenoxylate HCl)
3-6 months	3 mg.	½ tsp. 3 times daily
6-12 months	4 mg.	½ tsp. 4 times daily
1-2 years	5 mg.	½ tsp. 5 times daily
2-5 years	6 mg.	1 tsp. 3 times daily
5-8 years	8 mg.	1 tsp. 4 times daily
8-12 years	10 mg.	1 tsp. 5 times daily

Adults: 20 mg. (2 tsp. 5 times daily or 2 tablets 4 times daily) Based on 4 cc. per teaspoonful. Maintenance dosage may be as low as one-fourth the initial daily dose.

Precautions: Lomotil, brand of diphenoxylate hydrochloride with atropine sulfate, is a Federally exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded. Lomotil should be kept out of reach of children since accidental overdosage may cause severe respiratory depression. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates. The subtherapeutic amount of atropine is added to discourage deliberate overdosage.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness, insomnia, numbness of extremities, headache, blurring of vision, swelling of the gums, euphoria, depression and general malaise.

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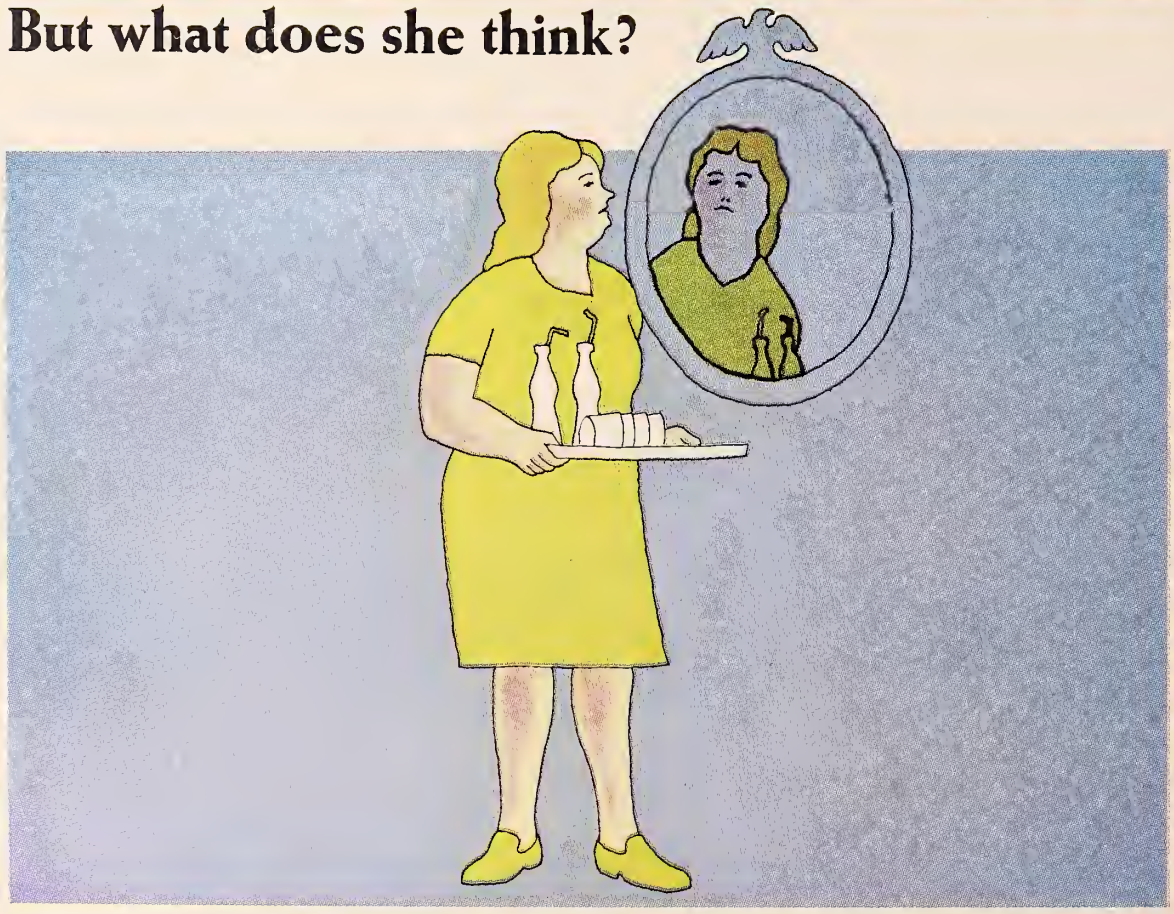

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Contraindications: Dextro-amphetamine sulfate: in hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.

Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness.

Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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Electrocardiogram
of the month

Presented as a regular feature of The JOURNAL, Electrocardiogram of the Month is a series of short talks on cardiovascular diagnosis and treatment, edited by the staff of the Krannert Heart Research Institute, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis.

Electrolytes and the T wave

CHARLES FISCH, M.D.
Indianapolis

THE nonspecificity of T wave changes is one of the major problems in clinical electrocardiography. The lack of understanding of the fact that organic myocardial or pericardial disease, drugs, changes in pH, electrolyte and hormonal disturbances, sympathetic and parasympathetic influences can produce similar ST-T changes has produced many "ECG cardiac cripples."

The tracings reproduced in Figure 1 were obtained on a 47-year-old man with Addison's disease. The ECG taken on 2-25-65 at which time the plasma K was 7.0 mEq/L demonstrates the classical features of hyperkalemia including low P waves, prolongation of the QRS and tall "tented" T waves and bradycardia (fourth row). Following intensive therapy which included large doses of adrenal steroids (2-29-65), the plasma K dropped to 3.0 mEq/L. This was associated with resumption of the normal heart rate (bottom row), shortening of the QRS and inversion of T waves indistinguishable from many other conditions which alter the T waves. With re-establishment of normal electrolyte pattern (3-9-65) the ECG returned to normal. ◄

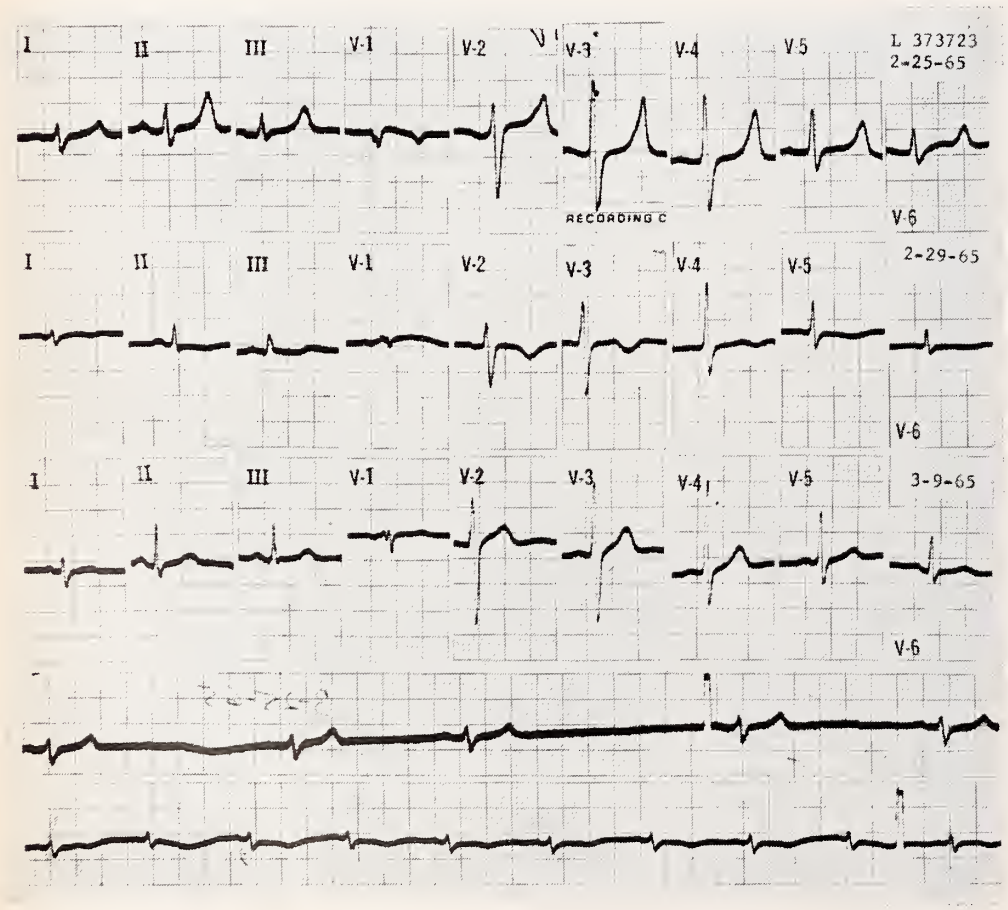

FIGURE 1
TRACINGS taken on 2-25-65, 2-29-65 and 3-9-65 reflect elevated, lowered and normal plasma K, respectively.

Behind continued high blood pressure readings lies the possibility of organic damage[1-13]

MANY OF THE aspects of essential hypertension are unpredictable—either because there are a number of mechanisms involved or because individuals differ in their responses to these mechanisms.[1]

There is one aspect of hypertension, however, that seems, in many cases, predictable. ". . . when the blood pressure is elevated to a marked degree for an adequate period of time, this in itself leads to perpetuation of the syndrome with resulting vascular damage throughout the body."[14] All too often the disease progresses until there is damage to one of three vital organs: the heart, the kidney, the brain.

"Hypertension is certainly a major factor in the genesis of coronary heart disease, and it is even more important when compounded with obesity."[4]

"[Vascular deterioration] can be clearly seen in the kidney with a degree of damage that can be measured by renal function studies."[10]

". . . most evidence suggests that reduction of blood pressure, when it is too high, not only relieves the heart of excess work but reduces vascular damage."[1]

"In short, treatment is indicated."[1]

Antihypertensive therapy will not restore the blood vessels to normal. Yet many of the vascular changes and symptoms caused by increased blood pressure may be arrested or alleviated when the blood pressure is reduced to normotensive levels.[7]

Reducing the blood pressure helps curtail further vascular damage and improves the prognosis — when damage is not too far advanced before therapy is started.[14] Essential hypertension is an indication not only for treatment, but for *early* and adequate treatment of the patient in question.

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Rautrax-N combines the antihypertensive-tranquilizing action of whole root rauwolfia with the antihypertensive-diuretic action of bendroflumethiazide in one convenient medication. The two drugs complement each other so that smaller doses of both are possible.

Rauwolfia combined with bendroflumethiazide is particularly effective in long-term therapy,[15-17] since beneficial effects do not diminish with continuous daily administration.

For most patients 1 or 2 Rautrax-N tablets daily are sufficient for maintenance therapy. The simplicity, convenience and economy of such a dosage schedule are of particular benefit to older patients.

References: **1.** Page, I. H., and Dustan, H. P.: The Usefulness of Drugs in the Treatment of Hypertension, in Ingelfinger, F. J.; Relman, A. S., and Finland, M.: Controversy in Internal Medicine, Philadelphia, W. B. Saunders Co., 1966, p. 95. **2.** Hollander, W.: The Evaluation of Antihypertensive Therapy of Essential Hypertension in Ingelfinger, F. J.; Relman, A. S., and Finland, M.: Controversy in Internal Medicine, Philadelphia, W. B. Saunders Co., 1966, p. 97. **3.** Nickerson, M.: Antihypertensive Agents and the Drug Therapy of Hypertension, in Goodman, L. S., and Gilman, A.: The Pharmacological Basis of Therapeutics, ed. 3, New York, The Macmillan Co., 1965, p. 727. **4.** Berkson, D. M.: Indust. Med. & Surg. **32**:371, 1963. **5.** Cohen, B. M.: M. Times **91**:645, 1963. **6.** Lee, R. E., et al.: Am. J. Cardiol. **11**:738, 1963. **7.** Moyer, J. H.: Am. J. Cardiol. **9**:821, 1962. **8.** Moser, M.: New York J. Med. **62**:1177, 1962. **9.** Wood, J. E., and Battey, L. L.: Am. J. Cardiol. **9**:675, 1962. **10.** Moyer, J. H., and Heider, C.: Am. J. Cardiol. **9**:920, 1962. **11.** Moser, M., and Macaulay, A. I.: New York State J. Med. **60**:2679, 1960. **12.** Judson, W. E.: Nebraska M. J. **44**:305, 1959. **13.** Hodge, J. V.; McQueen, E. G., and Smirk, H.: Brit. M. J. **1**:5218, 1961. **14.** Moyer, J. H., and Brest, A. N.: Hypertension Recent Advances, Philadelphia, Lea & Febiger, 1961, p. 633. **15.** Berry, R. L., and Bray, H. P.: J. Am. Geriatrics Soc. **10**:516, 1962. **16.** Reid, W. J.: J. Am. Geriatrics Soc. **13**:365, 1965. **17.** Feldman, L. H.: North Carolina M. J. **23**:248, 1962.

Contraindications: Severe renal impairment or previous hypersensitivity. **Warning:** Ulcerative small bowel lesions have occurred with potassium-containing thiazide preparations or with enteric-coated potassium salts supplementally. Stop medication if abdominal pain, distension, nausea, vomiting or G.I. bleeding occur.

Precautions and Side Effects: The dose of ganglionic blocking agents, veratrum or hydralazine when used concomitantly must be reduced by at least 50% to avoid orthostatic hypotension. Caution is indicated in patients with depression, suicidal tendencies, peptic ulcer; electrolyte disturbances are possible in cirrhotic or digitalized patients. Marked hypotension during surgery is possible; consider discontinuing two weeks prior to elective surgery and observe patients closely during emergency surgery. Rauwolfia preparations may cause reversible extrapyramidal symptoms and emotional depression, diarrhea, weight gain, edema, drowsiness may occur. Bendroflumethiazide may cause increases in serum uric acid, unmask diabetes, increase glycemia and glycosuria in diabetic patients, and may cause hypochloremic alkalosis, hypokalemia; cramps, pruritus, paresthesias, rashes may occur.

Dosage and Supply: Initial dosage, 1 to 4 tablets daily, preferably at mealtime. Maintenance, 1 or 2 tablets daily. Rautrax-N is supplied as capsule-shaped tablets containing 50 mg. Rauwolfia serpentina whole root (Raudixin®), 4 mg. bendroflumethiazide (Naturetin®), 400 mg. potassium chloride.

Also available: Rautrax-N Modified — capsule-shaped tablets containing 50 mg. Rauwolfia serpentina whole root (Raudixin), 2 mg. bendroflumethiazide (Naturetin), 400 mg. potassium chloride. Both potencies available in bottles of 100. For full information, see Product Brief.

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Squibb Rauwolfia Serpentina Whole Root (50 mg.) with Bendroflumethiazide (4 mg.) and Potassium Chloride (400 mg.)

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Path-finder
PUBLISHED UNDER THE AUSPICES OF THE INDIANA ASSOCIATION OF PATHOLOGISTS

This series is intended to emphasize the importance of judicious selection and proper interpretation of newer laboratory procedures as applied to differential diagnosis of various diseases. It is edited by Leon L. Blum, M.D., Terre Haute.

The Early Detection of Diabetes Mellitus

GREATER emphasis is being placed upon the importance of alerting the general public to the desirability of early detection of diabetes mellitus. Physicians will of course play the key role in this program, and they should be aware of the importance of utilizing methods of detection aimed at examining large numbers of clinically well individuals.

Automated methods of analysis now make it economically feasible to test large numbers of persons, and a significant number of those tested are being shown to have unsuspected diabetes mellitus. It has been estimated that in the United States there are two million or more people who are unaware that they have diabetes.[1]

Diabetes can be detected long before it becomes symptomatic, and early diabetes usually can be controlled with relatively simple methods. The key, therefore, in the problem of diabetes is early detection.

The two-hour post prandial blood sugar following a meal containing at least 100 grams of carbohydrate is the single most important measurement in the detection of early diabetes. Testing the urine for glucose is also important but glycosuria is usually a manifestation of late disease, and there often is no glycosuria in asymptomatic diabetes. Furthermore, the fasting blood sugar level may be within normal limits early in the disease.

The two-hour postprandial blood value below the upper limits of normal established for fasting sugar values excludes a diagnosis of diabetes mellitus. In general, however, a two-hour postprandial blood sugar above 140 mg.% strongly suggests its presence. Patients with two-hour postprandial values between 110-140 mg.% are in the doubtful range and all such patients should have a glucose tolerance test for definitive diagnosis. A normal repeat two-hour postprandial level may be misleading because the early diabetic may show only intermittent elevations of blood sugar.

For this same reason, the occasional high value obtained in a screening procedure needs to be rechecked several times before being considered as not significant or an error in technic. This is particularly true if the patient is pregnant, the relative of a diabetic or other type of individual who is a potential diabetic.

If a glucose tolerance test is necessary the patient must be placed upon a diet containing 250-300 grams of carbohydrate daily for at least three days before the test. This dietary requirement is a very important one because carbohydrate restriction, by itself, has been shown to impair the utilization of carbohydrate, presumably through a temporary decrease in pancreatic insulin concentration.[2] In this way an otherwise normal individual who has restricted his carbohydrate intake prior to a glucose tolerance test may falsely show a diabetic glucose tolerance curve.

In performing the glucose tolerance test, 100 grams of glucose in solution are ingested by the patient after fasting blood and urine specimens have been obtained. Blood and urine glucose values are then determined at one-half, one, two, three and four hour intervals after the ingestion of the glucose. The criteria upon which a diagnosis of diabetes mellitus is established vary somewhat due in large measure to the different normal values obtained by different methods for analyzing the blood sugar. The following figures pertain to values obtained by the Auto-Analyzer method. (Normal fasting range of values 70-110 mg. per 100 ml.) Blood sugar values consistently above 160 mg.% at one hour and above 120 mg.% after two hours in the absence of other disease, are diagnostic of diabetes. Values between 150 mg.% and 160 mg.% at one hour and between 110 mg.% and 120 mg.% after two hours are borderline and require a repeat glucose tolerance test or use of other tests such as a cortisone glucose tolerance or an intravenous tolbutamide test. In glucose tolerance tests occasional individual values may be altered because of unusually slow or rapid gastric emptying. Most authorities are in agreement that to make a diagnosis of diabetes mellitus the blood sugar following a glucose load should

*Prepared by the Section on Practice of Pathology in the Private Office, College of American Pathologists.

not only rise abnormally high but it should remain elevated for a prolonged period of time. Both the height and duration of elevation of the curve should be abnormal.[3]

Before a cortisone glucose tolerance test is done the patient should be put on a diet containing 300 grams of glucose daily for three days. If the body weight is below 160 pounds, 50 mg. of cortisone acetate is administered orally, eight and one-half hours and again two hours before the glucose tolerance test. If the weight is above 160 pounds, 62.5 mg. of cortisone acetate is administered each time. The patient is then given 1.75 grams of glucose per kilogram of ideal body weight and blood sugars are determined at 0, 30, 60, 90 and 120 minutes after glucose ingestion. Values above 160 mg.% at one hour and 140 mg.% at two hours indicate diabetes mellitus.[1]

The tolbutamide tolerance test makes use of the more rapid fall in blood sugar in the normal as compared to the diabetic individual when tolbutamide is administered intravenously. One gram of tolbutamide is given intravenously over a three minute period and blood for sugar determination is drawn 20 minutes and 30 minutes later. A fall in blood sugar at 20 minutes to less than 75% of the fasting level rules out diabetes. A blood sugar at 20 minutes, which is 90% of the fasting level indicates diabetes. A 30 minute value of 80% or more of the fasting level is diagnostic of diabetes. The test is quite reliable except during pregnancy when other hormone factors may interfere.

It must be emphasized that *not all diabetic-like glucose tolerance curves* mean diabetes mellitus. Similar curves are seen in patients with thyrotoxicosis, pheochromocytoma, Cushing's syndrome and acromegaly.

REFERENCES

1. Kesler, R. L.: *Illinois Med. J.*, April, 1965, p. 370.
2. Conn, J. W.: *Am. J. Med. Science* 199: 555, 1950.
3. Page & Culver: *Syllabus of Laboratory Examinations in Clinical Diagnosis*, Harvard University Press, Cambridge, Mass., 1960.

SYMPOSIUM ON ADOLESCENCE

NEW ORLEANS, LOUISIANA DECEMBER 1-3, 1966

Approved for 15 hours credit by the American Academy of General Practice
Sponsored by the

DIVISION OF PSYCHIATRY and COMMUNITY MENTAL HEALTH CENTER OF TOURO INFIRMARY
supported by a National Institute of Mental Health Grant

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Irvin Kraft, M.D., Professor of Child Psychiatry at Baylor Medical School, Houston, Tex.

John Schimel, M.D., Associate Director of William Alanson White Institute of Psychiatry, Psychoanalysis and Psychology, New York, N. Y.

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"Parents of Problem Children"
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"Sexual Morality — A College Dilemma"
"Drugs in the Treatment of Children and Adolescents"
"Learning Problems of the Adolescent"
"Adolescence and Social Mores"
"Talking About Sex with Adolescents"
"Religious-Psychological Conflicts"

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Enclosed is my registration fee of $20 for the SYMPOSIUM ON ADOLESCENCE to be given December 1-3, 1966 at the Fontainebleau Motor Hotel. (Checks should be made payable to Touro Infirmary.)

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of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

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Community Health Week

NATIONAL observance of Community Health Week, October 16 through 22, will give medical societies and all other members of the health services team their fourth annual occasion to show the public how they are organizing for better health.

The American Medical Association is urging local medical societies throughout the various states to institute some phase of observance of this week-long occasion, as suggested in the comprehensive kit of materials sent to local society officials throughout the nation.

It's an established fact that Americans today are living longer, healthier lives than ever before in history because of the enormous advances made in medicine and health care services.

Physicians, medical scientists and dedicated men and women in the many fields allied to medicine have combined forces to conquer polio, smallpox, diphtheria and other dread diseases which once took a heavy toll of life.

Community Health Week offers an excellent opportunity for medical societies to join in the observance of this week, along with allied health professions, public and private health organizations, civic organizations and public schools to demonstrate to the people the many health services and facilities that enrich their lives.

Guest Editorials

Doctor, Take the Witness Stand (2)

ROBERT E. HALES, M.D.
Oaklandon

THE DOCTOR is called as a witness. As physicians we are in a unique position as regards being needed to give expert medical testimony. Comes now the plaintiff. He has been injured, in fact blinded. It is not his fault, he feels. His entire case depends upon getting a doctor to take the stand and give his opinion. Too often the doctor will not assume his moral duty in this respect.

By far the most likely case at any given time in any courtroom selected at random is just such a personal injury action. An individual brings this sort of civil lawsuit for many reasons, of course. Most that go to trial and require medical testimony involve substantial sums of money. For example, the plaintiff may seek return of lost wages, money damages for pain and suffering, or money to replace the future dollars forever lost to his family through disability. A medical expert is crucial to our plaintiff's case. 70-80% of all lawsuits involve substantial issues of medical testimony.

There are three categories in which a physician may be called upon to testify: 1. As any other lay witness, 2. In a professional capacity, being the parties' physician and 3. In a professional capacity but not as one of the doctors who had assumed treatment responsibilities.

The doctor is asked for an opinion. This is difficult for many doctors. We like to rely on scientific proof. It seems in the aura of the courtroom that justice requires conclusiveness. Besides every day in the practice of medicine we are looked upon as a sort of omnipotent being; one who knows how long Jimmy has to live . . . indeed even how many days. But now we are on the witness stand. The judge and jury have to deal with medical conditions. This is new stuff to us. They await our opinions. But all that justice really requires in this context is reasonable probability.

Now let's get into the real life of trial methods, practice and procedure. How is an actual lawsuit carried out? By the adversary process. The adversary process is the very essence of our legal system. Yet, most doctors and many lay people highly mistrust what to them seems to be an arbitrary, crooked and "do-anything-to-win" sit-

uation. This demonstrates why this fundamental tenet, the adversary system, which operates at the very foundation of our legal process, is sorrowfully and sadly misunderstood.

The adversary system says to each side, convince me. Show me you're right as strongly as you can and surely the jury will then best be able to reach the truth. The main reason for the adversary system, in brief, is to afford the best possible means for getting at the truth. But doctors are scientists by background. We approach and explore matters objectively, cautiously and always strive for impartiality. This approach lends itself to medicine. But I submit that this is not the best approach for the law.

From the beginning, our nation has been determined to have and keep a free democratic judicial system, i.e., a judicial system free from government intervention. Indeed, juries are provided to further prevent the state from controlling the outcome of civil lawsuits. All court cases must be decided from the evidence presented in open court, open at all times to the public with both sides afforded the opportunity to challenge, cross-examine or impeach evidence presented by the adversary.

Usually two or more expert witnesses will testify in any one personal injury action. That is, one for each side. Much is made of the fact that medical expert testimony for one side always contradicts in certain respects the expert testimony for the other side. But in our setting of a free adversary approach, it's a foregone conclusion that each side is expected to present the best possible case for its client. An attorney will not put a witness on the stand whom he knows will testify contrary to his client's cause. Besides, it is almost impossible that all testimony, coming as it does from many different human beings and elicited by long and arduous direct examination, will be entirely free of inconsistency.

The trial is about issues, i.e., differences of opinion. Issues involve two sides. Reasonable men may differ.

Expert testimony is a safeguard in that it insures that the jury can be sure upon what facts the expert has based his opinion. That is, in most jurisdictions, the examiner must phrase his question to the medical expert by way of a hypothetical situation which will clearly articulate what set of facts the expert is to assume are true and upon which his opinion is henceforth based.

Thus the jury can decide how much weight to give this testimony in accordance with what the jury has determined the facts to be.

Oaklandon Medical Clinic
Oaklandon, Ind.

Contact Lenses and Unconscious Patients

ABOUT five million Americans are now wearing contact lenses. If a contact lens is allowed to remain on the cornea of an unconscious patient, considerable harm can be done. Even with the lids closed, circulation of tears beneath the lens stops and the corneal epithelium becomes devitalized and serious sequelae may follow.

Every unconscious patient should be checked to see if he is wearing contact lenses. It is not necessary to remove them completely; they can simply be pushed off from the cornea into the cul-de-sacs.

The method is as follows: Two fingers, usually the thumb and forefinger, are used to apply pressure to the outside of the eyelids and the lens moved into the upper or lower cul-de-sac. In this position the cornea will not be damaged and the lens can safely remain there for at least 24 hours. — **Dan G. Albert, M.D., Chairman, Section on Ophthalmology of the Medical Society of the District of Columbia.** Reprinted with permission from *Medical Annals of the District of Columbia* XXXV:330-331, June, 1966.

Las Vegas Host To AMA Clinical Convention

A scientific program especially designed for the physician in practice is scheduled for the 20th Clinical Convention of the American Medical Association.

The four-day meeting in Las Vegas Nov. 27-30 will include scientific sessions on 18 major topics, three postgraduate courses, breakfast roundtable conferences, closed-circuit television, medical motion picture programs and a variety of scientific exhibits.

Of special interest are the postgraduate courses, which have been expanded to three topics: Obstetrics and Gynecology, Fluid and Electrolyte Balance and Cardiovascular Disease. Each course will consist of three half-day sessions, each of which will feature several outstanding teachers. There will be a $10 registration fee for each course.

Lively discussion should be a feature of four breakfast roundtable conferences. The topics: "An Agonizing Reappraisal of Cancer Chemotherapy," "The Problem and Potential of LSD," "The Management of Metabolic Bone Disease" and "Indication for Cardioversion."

An outstanding program of closed-circuit color television and more than 25 medical motion pictures will be presented.

Topics at the scientific sessions include: scintillation scanning, radiation and cancer, clinical pulmonary physiology, gastroenterology, futuristic diagnostic and therapeutic tools, neck pain, antibiotics, urology, aerospace medicine, unconsciousness, dermatology, juvenile diabetes, endocrine and metabolic diseases, pediatrics, surgery, hematology, psychiatry and otolaryngology.

Scientific and industrial exhibits and all scientific meetings will be in the newly expanded Las Vegas Convention Center.

The AMA House of Delegates will meet in the Dunes Hotel and Caesar's Palace.

The Eighth National Conference on the Medical Aspects of Sports will be held in conjunction with the Clinical Convention. A day-long program of discussion of problems faced by team

physicians at all levels of athletic competition will be discussed. The meeting will be Sunday, November 27, at Caesar's Palace.

For advance registration at the Clinical Convention, write to the Circulation and Records Department, American Medical Association, 535 N. Dearborn St., Chicago, Ill., 60610.

For information on hotel reservations, write to the AMA Housing Bureau, Las Vegas Convention Bureau, Convention Center, Paradise Road, Las Vegas, Nevada. — **Suggested editorial from the American Medical Association.**

Editorial Notes . . .

E. R. Squibb & Sons, in order not to interrupt delivery on the large number of orders they receive for therapeutic and diagnostic radioisotopes, chartered three planes on July 9 when the airlines strike threatened to prevent delivery by commercial means. More than 4,000 deliveries were made during the first two weeks of the strike. One hospital performed 52 diagnostic scans with isotopes delivered thusly in a period of 10 days.

The Congressional Joint Committee on the *Reduction* of Nonessential Expenditures reports that, on June 30, 1966 there had been a net *increase* in Federal civilian employees in the Executive Branch of 230,129 over the figure of one year previously. This was the fiscal year in which the administration planned to reduce civilian employees by 25,000.

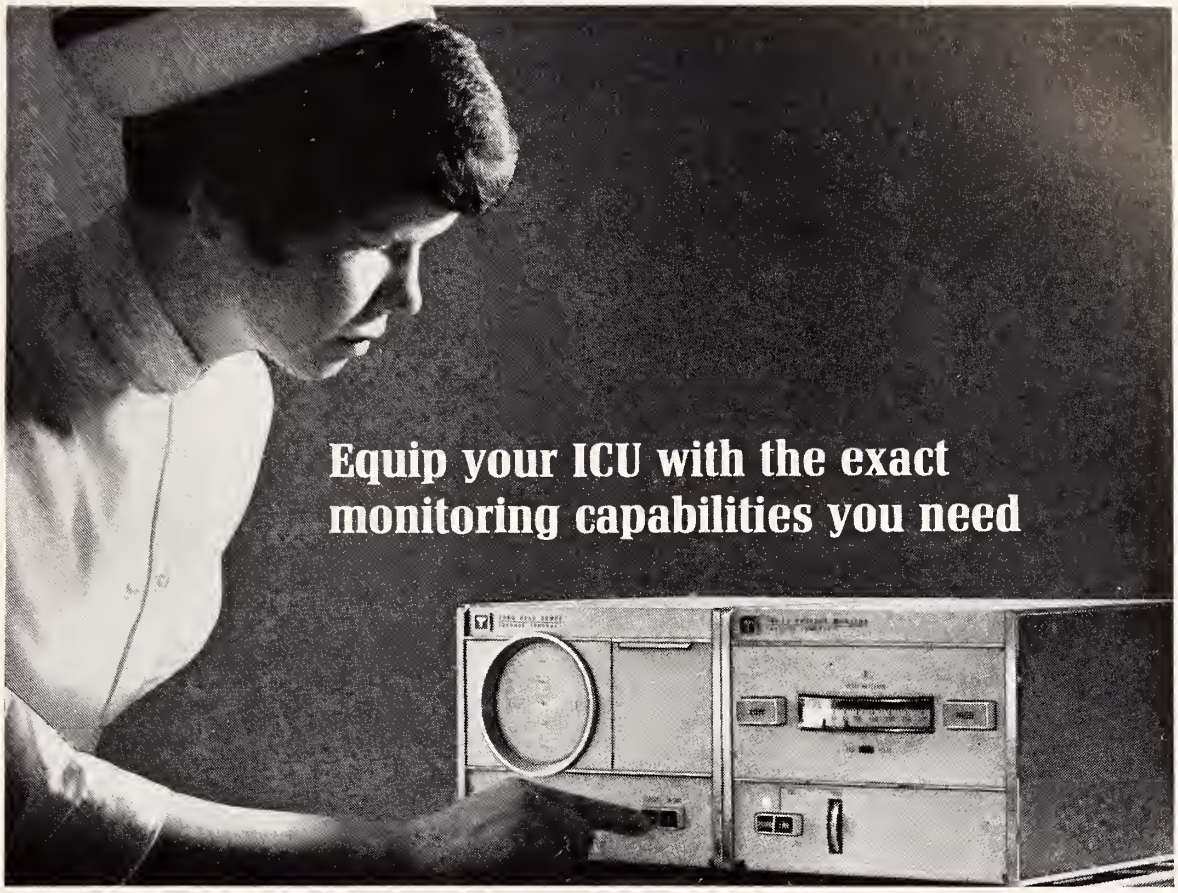
Tuberculosis is still a serious problem. In the ten years prior to 1963 the death rate dropped 70%, but the reported new active cases declined only 48%. New active cases are being reported at a national rate of 50,000 annually. There has been practically no drop in new cases since 1961, and 1963 was slightly higher than 1962. The larger cities contribute mostly to the new case register, and detection of new cases is the most important factor in control of the disease. In New York City, for instance, in 1960, 4.5% of new cases were reported for the first time on a death certificate, and over half of these had been undiagnosed and untreated.

Chromosomes may be counted and classified by computers, and in about 1/500 the time required by the original non-automatic system. The computer scans an non-enlarged photomicrograph and produces a graph of the chromosomes arranged and classified by length and by centromere position as in the classic karotype. The slow method requires enlargement of the photomicrograph, manual separation of each chromosome image, and tedious matching of pairs and arrangement by types.

One type of auto driver is the one who is slow to size up a situation but reacts quickly and positively. There is evidence that this is the type of driver who is struck from behind more often than is the case for other types of reaction. The Public Health Service supported a research study of taxi-cab drivers, 127 in number, to reach the above conclusion. The applicability may be limited to cabbies alone since they are subject to frequent emergency stop instructions from their fares.

Hospital expense per patient day increased by $2.90 or seven percent during the past year, in short-term community hospitals. National average now is $44.48. Costs have been rising seven or eight percent each year for several years now, due mostly to the increasing cost for personnel. The number of employees not only increases slowly (now 246 full-time personnel per 100 patients), but hospital wage scales, even though they are lower than industry, are pulled up as industry wages go up. Indiana is in a region which almost duplicates the national average of cost per patient-day. Our region's cost is $44.44; 62.5 %of this goes for payroll.

The annual exodus of doctors from England, once estimated to be equivalent in numbers to one-fourth of the number of medical graduates each year, has increased recently and now may equal one-half of the annual M.D. output. This is a sad state of affairs, but it raises the prospect of an even sadder state. When Medicare gets worse and worse and all American medicine is socialized, there won't be any place for free doctors to go. ◀



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HP/Sanborn field offices can give you valuable help in system planning, installation and staff training — and provide continuing, local service. For details, send the coupon to Hewlett-Packard Company, Sanborn Division, Waltham, Mass. 02154. In Europe, H.P.S.A., 54 Route des Acacias, Geneva.

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President's Page

The past year has produced more trials and tribulations than any of us like to remember. If we remember but one thing of the past year it should be that only with unity can our profession remain free. This lesson should be long remembered by all of us: generalist and specialist alike. We cannot survive as a free profession, we cannot even survive as free individuals unless we understand that any freedom taken from one of us is taken away from all of us. I hope that each of you will increase your personal activities in behalf of the Indiana State Medical Association. The ISMA needs your support now and you will need the support of the ISMA more and more as many social changes are forced upon our profession. Only a strong, active, knowledgeable membership working together can provide the foundation for the profession to remain a free, uncontrolled medical profession.

I have appreciated the honor you bestowed upon me in permitting me to serve as your president. Meeting many physicians in near-by states and exchanging philosophies and ideas with them has indicated to me that there is still hope for our profession to remain free in the new social order. But only if we can join forces to meet the challenge.

We need to create a more imaginative and forceful image of our profession. We should clearly define our philosophy, our motives and our objectives to the point that we need not be afraid of outside pressures. Only the medical profession can provide the services needed to supply the health care needs of this country.

Not even those who would destroy our profession, or those willing to reap temporary gain and recognition by the abandonment of the principle of private medical care and free enterprise can provide these services, except with the assistance of a wavering majority.

If change is needed, we should not be hasty to change because of the pressures of social planners or government agencies. We must stand ready to make those adjustments only after careful study and review clearly indicates that such change is needed to better the health care of our patients. We cannot bury our heads in the sand, neither should we plunge into a new program without careful deliberation and study.

My sincere best wishes go to your new officers. I know them to be capable and conscientious. I would ask your unqualified support for them in the year and years to come.

K. D. Neumann M. D.

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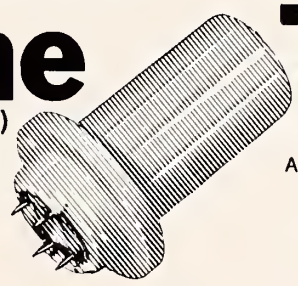

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The Woman's Auxiliary

REPORTS TO ISMA

The summer is behind us, vacations are over, children and young people have returned to school and we adults are rapidly becoming more aware of the nearness of November and the election which it brings. Many authorities feel that this is our last chance to "stop the trend" before it passes "the point of no return."

The current issue of AMPAC's newsletter, *Political Stethoscope,* gives the highlights of its recent National Workshop in Washington. "Delegations from 50 states attended the American Medical Political Action Committee's largest, most productive and most advanced National Workshop on May 21-22. . . . The intensive two-day course on how to win Congressional elections merged the best tactics of the cracker barrel era with dramatic computerized campaign tools of the mid-twentieth century. Elected national figures from both political parties shared the platform with specialists in campaign management. They concentrated on the practical ingredients of running elections. Time and time again the audience of physicians, wives and executive secretaries was reminded of the need for money, volunteers, organization and effective planning.

"Previous workshops emphasized the motivational aspects of why physicians and their wives should be active in politics. Dr. Frank Coleman, AMPAC chairman, set the tone of this session in his opening remarks by stating, 'The moment of inspiration is over. The question now is HOW can we WIN Congressional campaigns in November?' "

May I call your attention to a timely credo in which the author (unknown) has expressed the true aspirations of every real American?

My Creed

"I do not choose to be a common man. It is my right to be uncommon—if I can. I seek opportunity—not security. I do not wish to be a kept citizen, humbled and dulled by having the state look after me.

"I want to take the calculated risk, to dream and to build, to fail and to succeed. I refuse to barter incentive for a dole. I prefer the challenges of life to the guaranteed existence; the thrill of fulfillment to the stale calm of utopia.

"I will not trade freedom for beneficence nor my dignity for a handout. I will never cower before any master nor bend to any threat. It is my heritage to stand erect, proud and unafraid; to think and act for myself, enjoy the benefit of my creations and to face the world boldly and say, 'This with God's Help I have done!'

"All this is what it means to be an American!"

Mazo D. Scales

MOLECULAR REMODELING—

laboratory exercise or clinical necessity?

More than twenty-five years have passed since the discovery of the diuretic activity of sulfanilamide started pharmacologists on a succession of molecular remodelings to find the ideal diuretic.

Diuresis—a sought-after clinical effect from an unwanted side effect

It started in 1937 when a clinician reported that the administration of a sulfonamide was sometimes accompanied by an unexplainable side effect—metabolic acidosis.[1] Three years later the side effect was explained. The sulfonamide radical of sulfanilamide inhibited carbonic anhydrase,[2] the enzyme responsible for converting carbon dioxide and water to hydrogen ions and bicarbonate ions.

Later, other investigators showed by dog experiments that metabolic acidosis probably resulted when the inhibition of carbonic anhydrase upset the exchange of hydrogen and sodium ions, causing increased excretion of sodium as the bicarbonate.[3]

It was twelve long years after the first report of the unexplainable side effect (metabolic acidosis) that it was finally shown that large doses of sulfanilamide administered to edematous patients were indeed capable of promoting diuresis.[4] However, the possibility of toxic effects from its prolonged use and its relatively weak diuretic action made it impractical for clinical use as a diuretic.[5]

Because the inhibition of carbonic anhydrase seemed to be the key to effective diuresis, investigators began to look for more potent enzyme inhibitors —in the hopes that they would be more effective diuretics.

The most important of these early compounds, acetazolamide, enjoyed several years of fairly wide clinical use.

Its carbonic anhydrase inhibitory activity was several hundred times greater than that of sulfanilamide.[6] The increase in inhibitory activity, however, increased not only the excretion of sodium and bicarbonate ions, but also the excretion of potassium.[7] And, like its predecessor, acetazolamide precipitated mild acidosis. Its prolonged use could result in hypokalemic acidosis.[7]

The 'thiazides'—an answer to the metabolic acidosis caused by carbonic anhydrase inhibition

Despite the fact that the sulfonamide group appeared to be responsible for carbonic anhydrase inhibition which in turn appeared to be responsible for diuresis, investigators began to synthesize compounds with structural alterations to the sulfonamide group.

The first major breakthrough came with the synthesis of chlorothiazide. Altering the sulfonamide group did indeed alter the ability of chlorothiazide to inhibit carbonic anhydrase—it was only 1/10th as potent as acetazolamide in inhibiting the enzyme.[8] Despite the drop in inhibitory potency, however, chlorothiazide proved to be an effective diuretic—an observation that led to the conclusion that its diuretic action was due to some mechanism other than its action on carbonic anhydrase.[9,10]

For effective diuresis, chlorothiazide was administered in daily dosages ranging from 250 to 2000 mg.[11] It increased the excretion of sodium and chloride; and, to a lesser extent, potassium and bicarbonate.[11] The excretion of potassium appeared to be maximal at higher dose levels at which, theoretically, the carbonic anhydrase inhibitory effect is more active.[11] Its prolonged use, therefore, could sometimes result in metabolic hypokalemic, hypochloremic alkalosis.[7]

Naturetin—effective diuresis with more favorable electrolyte balance

Other thiazides followed—with improvements being aimed at two particular areas: 1. attempts to increase diuretic action in relation to the milligram potency of the drug, and 2. attempts at a more favorable sodium/potassium ratio in the urine, i.e., to decrease the excretion of potassium while maintaining the excretion of sodium.[12]

One of these, Naturetin, Squibb Bendroflumethiazide, has made advances on both these points. "By adding a 3-benzyl radical to hydroflumethiazide a rather dramatic reduction in dose range is accomplished. With this drug, effective sodium excretion is obtained with doses between 2.5 and 10 mg., which is a 200 to 1 ratio as compared to chlorothiazide..."[13]

Moreover, due probably to its virtual lack of carbonic anhydrase inhibition, Naturetin (bendroflumethiazide) has been shown to cause less potassium and bicarbonate loss and less alteration in urinary pH than either chlorothiazide or hydrochlorothiazide.

Naturetin is outstandingly effective not only in establishing, but also in maintaining, excretion of retained fluid in edematous patients. And its duration of action is sufficiently prolonged to allow a single daily administration in most patients. Naturetin is also an effective antihypertensive agent.

Contraindications: Severe renal impairment; previous hypersensitivity.

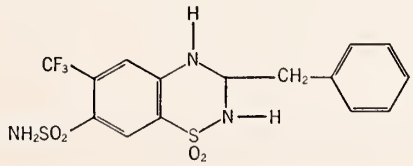
Warning: Ulcerative small bowel lesions have occurred with potassium-containing thiazide preparations or with enteric-coated potassium salts supplementally. Stop medication if abdominal pain, distension, nausea, vomiting, or G.I. bleeding occur.

Precautions: The dosage of ganglionic blocking agents, veratrum, or hydralazine when used concomitantly must be reduced by at least 50% to avoid orthostatic hypotension. Electrolyte disturbances are possible in cirrhotic or digitalized patients.

Side Effects: Bendroflumethiazide may cause increases in serum uric acid, unmask diabetes, increase glycemia and glycosuria in diabetic patients and may cause hypochloremic alkalosis, hypokalemia; cramps, pruritus, paresthesias, and rashes may occur.

Supplied: Naturetin (Squibb Bendroflumethiazide) 5 mg. and 2.5 mg. tablets. Also available Naturetin c̄ K [Squibb Bendroflumethiazide (5 or 2.5 mg.) with Potassium Chloride (500 mg.)]. For full information, see Product Brief.

References: **1.** Southworth, H.: Proc. Soc. Exper. Biol. & Med. *36*:58, 1937. **2.** Mann, T. and Keilin, D.: Nature *146*:164, 1940. **3.** Pitts, R. F., and Alexander, R. S.: Am. J. Physiol. *144*:239, 1945. **4.** Schwartz, W. B.: New England J. Med. *240*:173, 1949. **5.** Friedberg, C. K., in Moyer, J. H., and Fuchs, M.: Edema Mechanisms and Management, Philadelphia, W. B. Saunders Co., 1960, p. 259. **6.** Cumming, J. R.; Tabachnick, E., and Seelig, M., in Moyer, J. H., and Fuchs, M.: op. cit., p. 254. **7.** Werko, L., in Moyer, J. H., and Fuchs, M.: op. cit., p. 188. **8.** Beyer, K. H., Jr., in Moyer, J. H., and Fuchs, M.: op. cit., p. 274. **9.** Maren, T. H., and Wiley, C. E.: J. Pharmacol. & Exper. Therap. *143*:230, 1964. **10.** Earley, L. E., and Orloff, J.: Ann. Rev. Med. *15*:149, 1964. **11.** Fuchs, M., and Mallin, S. R., in Moyer, J. H., and Fuchs, M.: op. cit., p. 276. **12.** Ford, R. V., in Moyer, J. H., and Fuchs, M.: op. cit., p. 290. **13.** cited in Fuchs, M., and Mallin, S. R. (ref. 11): op. cit., p. 283.



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Medical Panorama

Dr. Roth on Medicare: Comment

A. W. CAVINS, M.D.
Terre Haute

The report of Chairman R. B. Roth, M.D., Council on Medical Service, AMA, analyzes Medicare problems to be faced by us doctors in our everyday practice. Published in *JAMA* Aug. 1, 1966, it covers specifically the areas of certification, re-certification, functions of utilization review committees, reasonable charge determination, deductibles, coinsurance, spell of illness, assignments, direct billing, hospital-based physicians, physicians services, emergency procedures, posthospital extended care facilities, psychiatric care, home health care, outpatient diagnostic coverage, services of interns and residents, status of beneficiaries, postgraduate medical education, health insurance coverage and statistical considerations.

This is a long list and is given here in full to show the many facets of Medicare which confront the practicing physician. No doubt other problems will appear as the system gets into high gear.

While every member of ISMA is urged to read this analysis, and judge for himself, a few comments here might be apropos.

On certification Dr. Roth states: "It has been suggested in the regulations that utilization - review committees should make spot checks as to the validity of certifications, but this is permissive and is not a statutory requirement." We have been advised by the AMA *not* to establish any utilization review committee specifically for Medicare purposes but to include Medicare functions in the activities of our regular staff committees (in most cases such committees already exist). Under this concept, if spot checks are considered desirable, they should be done on all types of hospital admissions — not just on Medicare admissions. This will maintain the status of the committee as a hospital and medical staff agency and prevent its becoming a mere policeman for Medicare. The corollary to this proposition is that if such spot checking is not desired or considered necessary for all patients, then it should not be done for Medicare patients.

Dr. Roth feels regarding certification that the "principal difficulty for physicians . . . will be that of explaining to patients that certain services, to which the patient believes himself entitled, are actually excluded from coverage, and that a certification cannot justifiably be executed."

Comment: while in many instances such a situation will be quite clear and unequivocal, there will be offers not so clear, and at such times the doctor will be tempted to certify, leaving it up to the carrier to weed out this type of case and to receive the onus of judgment. No harm would be done, unless the patient did not really need the service in the first place.

Dr. Roth's section on "Reasonable-Charge Determination" *should be carefully read.* It is, of course, obviously written with restraint and objectivity, which makes it a masterly understatement of some of the inconsistencies between points of view of doctors, regulation makers, carriers and legislators.

As to "deductibles," the first fifty dollars worth of services in any calendar year must be "reasonable charges" and at audit of these bills "amounts in excess of charges determined as 'reasonable' for such services and supplies will be discounted." And who is to say how much discount? — You guessed it.

Coinsurance: " . . . It still seems likely that many patients will be disturbed or unbelieving when they are told that the program will not pay the doctor in full or reimburse them in full for what they have paid the doctor.

"It is hoped that a clear authoritative official statement addressed directly to this matter will be available to physicians for use with their patients."

The portion on "assignments" is another reading "must." In addition to the issue of ethics involved, there are practical deterrents to the acceptance of assignments. Dr. Roth gives four: 1) the physician "must have assurance that the patient is covered by part B. knows the status of his deductible, and will take responsibility for any unsatisfied part of it"; 2) the necessity of collecting 20% of the "reasonable charge" will cause double-billing from the physician's office; 3) his ignorance of what the 20% will amount to until he knows what the carrier has allowed; and 4) the finality of the "reasonable charge" established for him by the carrier. As Dr. Roth says, "If he does not accept the assignment, he has no direct concern with any of these [factors] and he does not need to use any specific form in presenting his bill."

Under "Direct Billing" it is brought out that the AMA is producing a handbook of coding and nomenclature, the alleged need for which is explained in the article. It is stated that use of "the proper code for reporting his service to the carrier and for indicating the diagnosis will actually simplify things for the carrier and will provide a major obstacle for the curious patient." Perhaps we should think about this a little before snapping at it. Discussion of the

"receipted bill" is valuable and enlightening and brings up several matters "with potential import in respect to Internal Revenue Service interpretation."

The matter of "Hospital-Based Physicians" is so involved in controversy that comment on it here would be of little value. One important point made in regard to use of "an appropriate uniform percentage in determining the amount of the pathologist's charges to be reimbursed under the supplementary insurance plan" as a concession to the pathologists "is more apparent than real since the net result of the use of the optional billing must work out to be the same partition of expenses to part A and part B as would have been otherwise accomplished." The entire discussion is well worth reading.

Emergency Procedures: here there is a possible area of dispute with the powers-that-be regarding "the validity of an emergency treated in a noncertified institution."

Posthospital Extended Care Facilities: Expect trouble here, as the public probably has little understanding of the restrictions and conditions of participation under this portion of the law. The principle of requiring a three-day stay in a general hospital before admission to a nursing home will then become apparent, since this service is supposed to represent an extension of hospital care in cheaper facilities. If utilization review of all such facilities becomes the duty of the utilization committee of the hospital holding the transfer agreement, the physicians involved are likely to feel unwilling to accept such a duty. This would tend to jeopardize the hospital's own program. Therefore, it would be well for staff members to alert themselves to what is being contemplated right now by their respective hospital administrations in the matter of transfer agreements with nursing homes. It seems to this observer, *at this time,* that staff physicians would do well to insist on "tending to their own knitting" in their own hospital.

Psychiatric Care: Here there is quite a difference from general medical care, and special problems will arise.

Home Health Care: This is an interestingly complicated situation because it reveals an inconsistency in the fundamental philosophy of paying for the services of physicians as compared to others. According to Dr. Roth, "part-time or intermittent nursing care, physical therapy, occupational therapy, medical social services, medical supplies other than drugs or biologicals, and the services of interns or residents in approved hospital-affiliated programs are covered to the extent of 100 visits 'and payment' by the part A intermediary is *in full* for reasonable cost, directly *to the providers.*" [Italics ours.] No 80% payment here — and no deductibles, either. However, the physician, at 80% is still key-man in the program. Here again, direct billing is the only answer.

Outpatient Diagnostic Coverage: The last paragraph in Dr. Roth's article contains the meat here.

Services of Interns and Residents: Again, the last paragraph is especially important, and shows the law as interpreted by regulations of the Social Security Administration to be as repugnant as in some other areas. AMA testimony has apparently been disregarded.

Status of Beneficiaries: No comment.

Postgraduate Medical Education: This should be read. The effect here on Medicare is so unpredictable that "wait and see" is indicated.

Health Insurance Coverage: This is a short but clear exposition of the insurance "industry's" attempt to avoid duplication of coverage by use of "disincentives" and the possible role of "antidisincentives" in nullifying the advantage of such restraints.

Statistical Considerations: Statisticians are earnest people, and would have everyone else running around in circles gathering figures for them, if they had their way. Carriers "seem to be obligated to develop an extensive file on each physician who provides service in the program. This file will need to include information on medical education, specialty training, type of practice (i.e., solo, partnership, group, hospital-based, etc.) and a profile of charging practices." While there is a necessity for basic statistical analysis of the program, concern "has been expressed, however, that this shall not involve unjustifiable invasions of privacy."

Dr. Roth then concludes with remarks on the "fundamental incompatibility" between the provision of Section 1801, entitled "Prohibition Against Any Federal Interference" (with the actual practice of medicine) and "some of the many provisions that follow throughout the balance of the act, and in its regulations." The answer, of course, lies in the Fabian point-of-view of those who have worked for 35 years, or more, to bring this about: the end justifies the means. As Virgil put it, "Timeo Danaos, et dona ferentes." ◄

Drug Dilemma for Medicare Patients

I share the view of many that the (hospital) pharmacy and therapeutics committee, even when it operates most effectively, offers an incomplete and illusory method of providing the Medicare patient's drugs.

The range of drugs available to the patient may vary with the hospital. The patient who leaves the hospital and enters a nursing home may find that his drug supply is no longer paid for. I confess confusion as to why these patients are not permitted to have the same drugs the rest of us use, in light of this country's extremely rigid drug law and a $54,000,000 FDA budget to enforce it. — C. Joseph Stetler, LL.M., in *Texas State Journal of Medicine,* (62:38), April, 1966.

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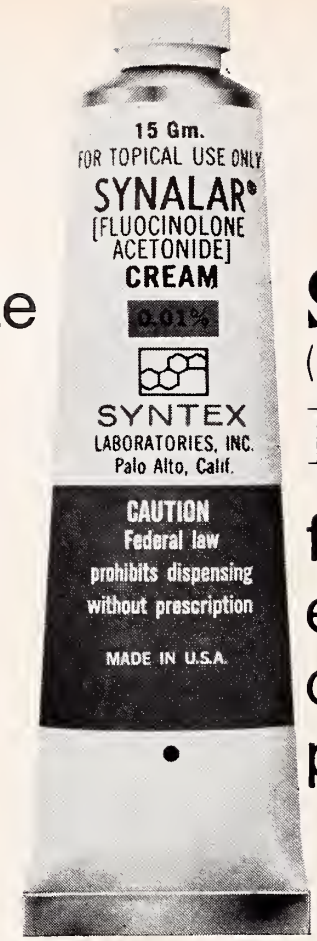

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Contraindications: Tuberculous, fungal, and most viral lesions of the skin (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of its components. **Precautions:** 1. *General*—Synalar Cream 0.01% is virtually nonsensitizing and nonirritating. Where severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. 2. *Occlusive dressing method*—With occlusion of extensive areas, systemic absorption of the corticosteroid may occur, and suitable precautions should be taken. Occasional patients may show contact sensitivity to a particular dressing material or adhesive. Miliaria, folliculitis, or pyodermas have been seen infrequently with the use of this technique. The development of infection requires appropriate antibacterial therapy and discontinuation of the occlusive dressing method. Local atrophy and striae have been reported with protracted occlusive dressing therapy. While lesion relapses can be expected to occur in many psoriatic patients, remissions may persist for several weeks to several months in favorable cases. The patient whose psoriasis is in an active stage, with recent appearance of new lesions, may not be a good candidate and may show early relapse. Some plastic films may be flammable, and due care should be exercised in their use. Similarly, caution should be employed when such films are used on or left near children to avoid the possibility of accidental suffocation. **Side Effects:** Side effects are not ordinarily encountered with topically applied corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. **References:** 1. Cahn, M. M., and Levy, E. J.: J New Drugs 1:262 (Nov.-Dec.) 1961. 2. Meenan, F. O.: J Irish Med Ass 52:75 (Mar.) 1963. 3. Robinson, H. M., Jr., Raskin, J., and Dunseath, W. J. R.: Southern Med J 56:797 (Jul.) 1963.

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Medicine At Law

DECISIONS AND OPINIONS

Highlights of recent court actions pertaining to health and medicine from *The Citation* prepared by the Law Division of AMA.

City Not Liable for Medical Examiner's Performance of Autopsy Without Consent — The husband of a deceased hospital patient was not entitled to recover damages in a suit against the city for the medical examiner's performance of an autopsy on her body to which the husband had refused to consent, the New York Court of Appeals ruled.

The medical examiner investigated the case after the Board of Health refused to accept the death certificate on the ground that the stated causes of death, "peritonitis" and "perforated viscus," were both general terms which conveyed no definite information of the actual cause of death. When he was unable, after his investigation, to determine the exact cause of death, the medical examiner performed the autopsy.

The medical examiner is authorized by statute to perform an autopsy on the body of a person dying in an "unusual" manner. The fact that the autopsy findings sustained the decision to make it was not determinative of the medical examiner's authority to do so. His authority must be judged on the basis of the situation facing him when he made his decision. The record showed that, although the hospital had made a wide range of tests and followed a wide range of procedures in treating the patient, the hospital physicians had been unable to make any definitive diagnosis. This, combined with the Board of Health's refusal to accept the death certificate, was sufficient to support the conclusion that the patient's death was "unusual," the court said. Since the medical examiner acted within his statutory authority in performing the autopsy, the city could not be held liable.

Cremonese v. City of New York, 267 N.Y.S.2d 897 (N.Y., Feb. 17, 1966).

Percentage Rental Leases Not Ground for Denying License to Proprietary Hospital — The refusal by the city commissioner of hospitals to renew the license of a proprietary hospital, on the ground that the percentage rental provisions in its lease of the hospital premises and the sublease to two physicians of the x-ray facilities permitted the landlord to participate in the proceeds of the practice of medicine, was improper, a New York trial court ruled.

The hospital and the landlord dealt at arm's length in negotiating the lease. There was no showing that the landlord exercised any control or had any right under the leases to interfere with the operation of any hospital facility or any voice in setting the hospital's operating policies. The provisions in the lease and the sublease for percentage, rather than fixed, rentals in no way affected the landlord's position with respect to the hospital's operation. The sublease was not unethical or unlawful as between the hospital and the physicians because the rent provided for was well below the percentage permitted by statute. Thus, there was nothing improper in including the rent paid by the physicians in the hospital's gross receipts on which its percentage rental payment to the landlord was based.

Kew Gardens Sanitarium, Inc. v. Trussell, 267 N.Y.S. 2d 763 (N.Y., Feb. 28, 1966).

Ophthalmologist Liable for Unauthorized Surgery — A patient whose eyelid drooped following surgery for the removal of a freckle from it was entitled to recover damages in a suit against an ophthalmologist, where the ophthalmologist had not obtained the patient's consent to the surgery, a Michigan intermediate appellate court ruled.

The patient consulted the ophthalmologist about what appeared to be a sty on his lower left eyelid. The ophthalmologist diagnosed the condition as infected meibomian glands and said they would have to be opened and drained to relieve the pain. He administered a local anesthetic in the eye, draped the lid with a sterile towel, and removed some meibomian glands and a freckle from the eyelid. In removing the freckle, the tarsus was cut, thus causing the eyelid to droop.

The freckle was not mentioned to the patient and his consent to its removal was not obtained. Its removal was unauthorized and unwarranted, and constituted assault and battery. There was clearly no emergency which justified its removal without first obtaining the patient's consent. There was no merit to the contention that the patient, being a dentist, knew that surgery was to be performed when he saw the syringe prepared and the towel, and that his failure to object constitut-

ed consent to the surgery. The patient could not see or feel the surgery as it progressed. He had previously had a similar infection removed by nonsurgical procedures and it was not unreasonable for him to assume that the ophthalmologist would use the same procedure.

Shulman v. Lerner, 141 N.W. 2d 348 (Mich., April 12, 1966).

Patient's Communications to Unlicensed Intern Privileged — In a suit by an insurer to rescind a policy, a federal trial court properly excluded an intern's testimony as to what the insured told him while he was taking his medical history on the ground that the information so obtained was privileged, the U.S. Court of Appeals for the Sixth Circuit ruled.

The insurer contended that the privilege was not applicable because the intern was not licensed to practice as a physician when he took the history. He was on "medical service" and part of his duties was the taking of patients' medical histories. In doing so, he acted under the direction of the attending physician and the hospital administrator.

Some jurisdictions hold that the physician-patient privilege applies to communications to those assisting the physician in his treatment of the patient, while other jurisdictions hold that it does not. If an intern can properly be said to be the physician's agent in taking part in a patient's treatment, the privilege applies to the intern as it would to the physician in whose behalf he acts, the court said. When the intern took the insured's medical history, he acted as the attending physician's agent and the information he obtained in the course thereof was privileged.

Franklin Life Insurance Company v. William J. Champion and Company, 353 F. 2d 919 (C.A. 6, Dec. 22, 1965).

One General Surgeon's Testimony Prevails Over That of Several Specialists in Compensation Case — The finding of a deputy commissioner, in a proceeding to recover workmen's compensation benefits, that there was a causal connection between the industrial injury and the claimant's disability was supported by competent and substantial evidence. The order of the full commission, substituting its contrary finding, was, therefore, improper, the Florida Supreme Court ruled.

The deputy commissioner based his conclusion that there was a causal connection between the injury and the disability on the unequivocal testimony of a general surgeon, who seemed familiar with the claimant and his condition. Three board-certified orthopedists and two specialists in the field of arthritis were witnesses for the employer. They testified that the claimant's disability was caused by a congenital deformity and progressive arthritis, rather than by the injury.

The rule is established that a deputy commissioner's finding of fact will not be disturbed if it is supported by evidence believed by him, so long as the evidence is competent and substantial and comports with reason and logic. The full commission appeared to have accepted the testimony of the physicians who were the employer's witnesses because they were specialists, rather than because the general surgeon, whose testimony was preferred by the deputy commissioner, was incompetent or his testimony was unreasonable or illogical. It might also be that the full commission was unconsciously influenced by the fact that the employer's medical experts greatly outnumbered the claimant's, the court said.

Crowell v. Messana Contractors, 180 So. 2d 329 (Fla., Oct. 20, 1965; rehearing denied, Dec. 13, 1965).

Physician and Hospital Exonerated in Patient's Suit for Staph Infection Following Surgery — In a suit for damages against the insurers of a physician and a hospital by a patient who developed a staphylococcus aureus infection in his incision several days after a hernia operation, a trial court did not err in directing a verdict for the insurers, the U.S. Court of Appeals for the Fifth Circuit ruled. The patient failed to sustain his burden of establishing a causal connection between the physician's and the hospital's alleged deviations from accepted professional standards and the infection.

LeFort v. Massachusetts Bonding and Insurance Company, 358 F. 2d 741 (C.A. 5, April 11, 1966).

Compensation Denied for Mental Breakdown Caused by Conflicting Pressures of Management and Union — An employee who suffered a mental breakdown as the result of conflicting pressures put on him by the employer and the union as to the amount of work he should perform was not entitled to workmen's compensation benefits, the Kansas Supreme Court ruled.

The employer had threatened the employee with disciplinary action if he did not meet a production quota, while the union demanded that he keep his production down so that the piece rate would not be set too high. The rule permitting recovery for traumatic neuroses directly resulting from a physical injury was not applicable because the employee suffered no physical injury. An injury arises out of employment and is compensable where it is causally connected with the conditions under which the work is required to be performed. The psychiatrist who treated the employee testified that his mental breakdown was not caused by his workload or his job's physical requirements, but by a depressive reaction to the conflicting demands. This testimony supported the conclusion that the mental breakdown did not arise out of the employee's employment. Further, the union pressure, without which the employee would probably have experienced no difficulty, was an external force as to which the employer had no control or responsibility.

Jacobs v. Goodyear Tire & Rubber Company of Kansas, 412 P. 2d 986 (Kan., April 9, 1966).

Osteopath's Libel Suit Barred by Absolute Privilege — An osteopath was not entitled to recover damages in a suit against the chairman of a hospital surgery department for allegedly libel-

ous statements made by the chairman in a letter to the credentials committee of the hospital, a Michigan intermediate appellate court ruled.

The department chairman notified the osteopath in writing that, on the basis of a review of his work at the hospital for the past year, he was to be under supervision in all of his surgical procedures until further notice. The osteopath then asked the chairman to provide him with a list of the specific charges against him. The chairman wrote a letter setting forth charges of gross mismanagement of surgical cases, unprofessional conduct and lack of cooperativeness. The letter was written in longhand by the chairman and was typed by his secretary. Copies were sent to the osteopath, the hospital's administrator and its credentials and executive committees.

It was clear that the letter was written by the chairman and the copies sent to the other persons because of the osteopath's request. The osteopath made the request so that he could follow the appeal procedures provided for in the hospital's constitution. The publication of false and defamatory matter about another is absolutely privileged if the other consents thereto, the court said. The osteopath's request for a specification of charges also authorized the chairman to use his secretary to communicate them to the osteopath.

Schechet v. Kesten, 141 N.W. 2d 641 (Mich., April 26, 1966).

Physicians and Hospital Not Liable for Patient's Cardiac Arrest During Childbirth — Damages could not be recovered in a suit against an obstetrician, an anesthesiologist and a hospital by a patient who suffered a cardiac arrest during childbirth, a California intermediate appellate court ruled.

The patient was in hard labor for more than 11 hours without making substantial progress toward delivery. Because of this, the patient's size and the size of the child, the obstetrician decided that a Caesarean was necessary. He sought consultation, as the hospital rules required for a first time Caesarean, but the physician he called was not available. The patient's husband consented to the procedure. The obstetrician called in the anesthesiologist and, after discussing the case, they decided to use spinal anesthesia. When the patient was told that a spinal anesthetic was going to be given, she made no objection and cooperated in its administration.

Shortly after the anesthetic was administered, it became apparent that the child would be delivered vaginally, and the patient was put in the proper position. When the obstetrician did an episiotomy, he observed that the blood was cyanotic. He informed the anesthesiologist who began to force oxygen into the patient's lungs. Almost immediately afterwards, the patient suffered a cardiac arrest. The obstetrician opened the patient's chest and started cardiac massage, while the anesthesiologist inserted an endotracheal tube and administered oxygen. After about 10 minutes, a spontaneous heart beat was obtained.

The obstetrician testified that he did not know what caused the cardiac arrest, but that one could occur even when due care was used. Another obstetrician testified that delivery was handled in accordance with the standards of practice in the community. He stated that it was proper, under the circumstances, to have arranged for a Caesarean even though no consultation was held, and that a spinal was the anesthesia of choice in a case such as this. The anesthesiologists who testified for the patient and for the two physicians both stated that the anesthesiologist's failure to take a medical history and to make a physical examination before administering the spinal was not good medical practice, but that there was no causal connection between that omission and the cardiac arrest. The anesthesiologist who testified for the patient stated the opinion that the cardiac arrest had been caused by a high spinal anesthesia, but his explanation of the basis for his opinion was not convincing. The anesthesiologist who testified for the two physicians stated the opinion that the spinal anesthesia did not cause or contribute to the cardiac arrest.

The patient contended that an inference of negligence arose under the doctrine of res ipsa loquitur as to the anesthesiologist, and that the inference had not been met or overcome. The trial court's conclusion, that the cardiac arrest was not due to negligence but to some unknown and unpreventable cause, was supported by the evidence, the court said. The two physicians were not required to show what the exact cause of the cardiac arrest was.

The evidence failed to show any deviation from the standard of practice in obtaining consent to the Caesarean or to the spinal anesthesia.

The same evidence that supported the finding that the anesthesiologist was not liable applied equally to the obstetrician.

The patient sought to hold the hospital liable on the theory that the two physicians were its agents. Since they were not responsible for the injuries complained of, no determination on the issue of agency was necessary.

Dunlap v. Marine, 51 Cal. Rptr. 158 (Cal., May 11, 1966). ◄

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*Schiller, I. W., and Lowell, F. C.: New England J. Med. 261:478, 1959.

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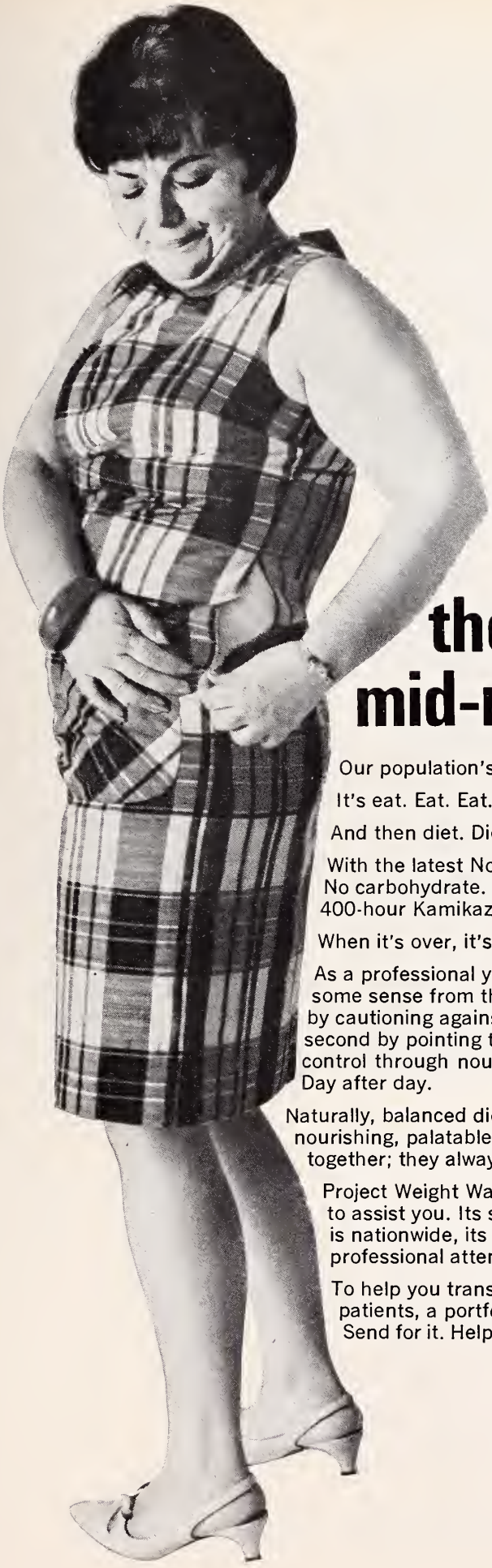

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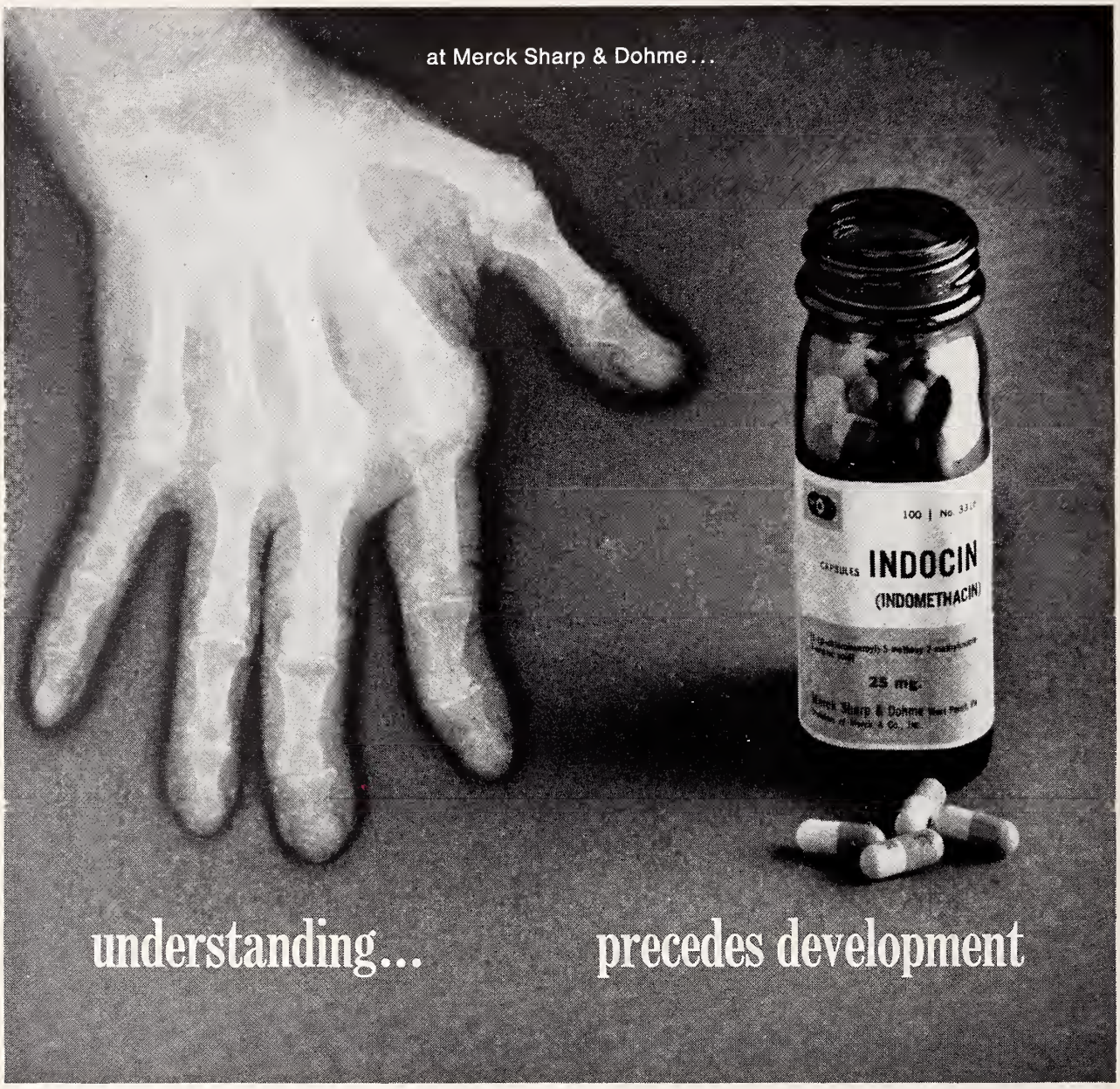

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This is not easy for me to say because as a physician, I would hope that physicians would lead the way in this important venture. They and their patients would benefit most from an orderly information system within the medical community. — James L. Goddard, M.D., to American Society of Internal Medicine, New York, April 15, 1966.

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Enayat Keshavarz, 94 Amity St., Brooklyn, N. Y. 11201 — *Ear, Nose and Throat* (available January, 1968)

Martin C. McHenry, Henry Ford Hospital, 2711 W. Grand Blvd., Detroit, Mich. 48202 — *Internal Medicine*

David D. O'Hara, 112 Colorado St., Travis AFB, California 94535 — *Internal Medicine*

Myron T. Potter, 1412 Berkman Ct., Rochester, Minn. 59902 — *Internal Medicine*

I. Richard Weiss, 27142 Yorkshire Sq., Apt. 106, Dearborn Heights, Mich. 48127 — *Internal Medicine*

Mehmet H. Onder, P.K. 84, Samsun, Turkey — *Internal Medicine*

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John N. Haswell, Station Hospital, Patuxent River, Maryland — *Ob-Gyn.*

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ABSTRACTS

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CURRENT PEDIATRIC THERAPY 1966-67

Sydney S. Gellis and Benjamin M. Kagan, W. B. Saunders Co., Philadelphia, 1966; 956 pages; $17.50.

Dr. Sydney S. Gellis is the author of the tremendously successful *Yearbook of Pediatrics*. The enormously popular *Current Therapy*, also put out by Saunders, has made inevitable the present volume.

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This volume is a worthy companion to Conn's *Current Therapy*. It can be recommended without reservation.

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New York, N. Y.

Abstracts From Various Literature, Prepared by AMA

HYPERTHYROIDISM AND THYROID CANCER

E. Olen and C. H. Klinck (Armed Forces Institute of Pathology, Washington, D. C.)

Arch. Path. 81:531-535, (June), 1966.

Fifty-three thyroid cancers were found among portions of 2,114 thyroids from thyrotoxic patients. The association of hyperthyroidism and thyroid cancer may be clinically significant. Most of the tumors were small, and more than half were of the occult sclerosing type. Eighteen were papillary cancers, five were follicular and three poorly differentiated. Forty-two of the cancers were in diffuse toxic goiters, and 11 were in nodular toxic goiters. Four of the cancers had spread to regional lymph nodes, but there were no distant sites of metastasis. All the patients had been treated with thiourea derivatives and iodine, except two of the hyperthyroid patients who had received radioactive iodine 131.

CONTINUOUS INTERCOSTAL NERVE BLOCKS FOR POSTOPERATIVE PAIN RELIEF

M. A. Ablondi et al. (15 Ashton Ave., Newton, Mass.)

Anesth. Analg. 45:185-190, (March-April), 1966.

A simple and effective method of performing continuous intercostal nerve blocks for the control of postoperative pain following upper abdominal, thoracic and urologic operations is presented. In this method "Rochester" plastic needles are quickly and easily inserted into the appropriate intercostal spaces at termination of the operation while the patient is still anesthetized. One percent mepivacaine (Carbocaine) is the anesthetic agent used. Once inserted, the plastic needles are left in place and injected intermittently every four hours or whenever the patient complains of pain. This technic is particularly valuable in patients with chronic bronchopulmonary disease, because it permits them to deep breathe and cough effectively. In the 140 cases that are reviewed only one complication, a tension pneumothorax, is reported.

CARDIAC ARREST AFTER MYOCARDIAL INFARCTION

J. F. Pantridge and J. S. Geddes (Royal Victoria Hosp., Belfast, Ireland)

Lancet 1:807-808, (April 9), 1966.

The value of intensive care units in reducing the mortality from cardiac arrest after myocardial infarction has been substantiated. However, their role is limited by the fact that most patients who develop cardiac arrest after myocardial infarction do so before they have reached such units. A highly mobile resuscitation team, operating over a wide area within the confines of a large general hospital, can save approximately a third of the patients who have a cardiac arrest after myocardial infarction. Since the majority of deaths from cardiac arrest happens immediately after the onset of infarction, a mobile resuscitation team should be able to reach the patient in his own home.

PREDNISONE IN EMERGENCY TREATMENT OF MALIGNANT EXOPHTHALMOS

S. C. Werner (Columbia University College of Physicians and Surgeons, New York)

Lancet 1:1004-1007, (May 7), 1966.

The critical emergency created by advanced eye changes of Graves' disease (malignant exophthalmos) was successfully managed medically with 120 to 140 mg daily of prednisone in two patients in whom the prognosis had been regarded as hopeless. The final outcome is uncertain, particularly in regard to the possible prevention of a recurrence and the maintenance of remission by slow withdrawal of the steroid. Improvement of the eye symptoms and muscle function has been maintained for three months, so far, despite progressive reduction in steroid dosage. In prednisone therapy of the severe eye complications of Graves' disease, there may be a critical threshold dosage which must be exceeded for a satisfactory result.

INDOMETHACIN IN RHEUMATIC DISEASE: A REASSESSMENT

R. G. Robinson (Royal North Shore Hosp., Sydney, Australia)

Med. J. Aust. 1:971-972, (June 4), 1966.

The use of indomethacin has been evaluated previously in a study of 193 patients treated by oral administration and now in 48 patients treated with rectal suppositories. The selection of these patients, the problems involved in their management and the treatment of side effects are discussed. The results indicate it to be a valuable agent in the treatment of many rheumatic illnesses. When oral medication is used, some 70% of patients showed beneficial effects from the drug, but nearly one third of these developed adverse reactions. Of these, however, a major proportion could be successfully managed by treatment with indomethacin suppositories.

SILVER NITRATE TREATMENT OF THERMAL BURNS: A CRITIQUE OF FOUR MORTALITIES UNDER THIS PROGRAM

M. Lentz, R. Seaton, and B. G. Macmillan (Department of Surgery, Cincinnati General Hosp., Cincinnati)

J. Trauma 6:399-406, (May), 1966.

Theoretical considerations in the therapy of burn wounds with silver nitrate soaks are discussed in the light of four patients, all of whom died. In three of the cases, the treatment produced a clean surface. Limited experience does not imply a condemnation of this therapeutic approach; rather, it suggests that caution and experience with the treatment are necessary to avoid complications.

Continued

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EFFECT OF THALIDOMIDE ON SURVIVAL OF SKIN HOMOGRAFTS IN RABBITS

P. J. Bore and R. J. Scothorne (The University, Newcastle upon Tyne, England)

Lancet 1:1240-1241, (June 4), 1966.

Thalidomide did not prolong the survival of skin homografts in New Zealand white rabbits. Results invalidate the hypothesis that thalidomide causes fetal abnormality by acting as an immunosuppressive agent and allowing the survival of malformed fetuses which would otherwise have been aborted.

EXTENDED RADIOACTIVE THERAPY IN ADVANCED HODGKIN'S DISEASE

R. E. Johnson et al. (Radiation Branch, National Cancer Institute, NIH, Bethesda, Md.)

Arch. Intern. Med. 118:70-74, (July), 1966.

A small series of patients with stage 3 Hodgkin's disease, having lymph node involvement of multiple areas both above and below the diaphragm, received irradiation to both the clinically and potentially involved major lymph node regions. There was no serious morbidity with respect to the hematological response, although significant changes in the peripheral blood counts were observed. The patients without constitutional symptoms were all clinically free of the disease with a minimum follow-up of six months. An additional patient with constitutional symptoms who received chemotherapy prior to irradiation is described to illustrate a potential approach in which systemic treatment is initially indicated to halt rapidly progressive disease or debilitating symptoms. It is feasible to utilize aggressive radioactive therapy in patients with relatively advanced Hodgkin's disease involving glands in multiple areas.

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PANCREATECTOMY FOR REFRACTORY HYPOGLYCEMIA IN CHILDREN

J. M. Stokes (100 N. Euclid Ave., St. Louis), H. J. Wohltmann and A. F. Hartmann

Arch. Surg. 93:40-48, (July), 1966.

Cases of six children with severe recurrent hypoglycemia included a two-year-old child with pancreatic islet-cell tumor which metastasized to the liver. The remaining five children were refractory to medical therapy over periods greater than six months. Subtotal pancreatectomy in these children effected marked improvement in the mean blood glucose in all six without significant morbidity. Neurological impairment was improved in three and unchanged in three. All those who were unimproved had a history of hypoglycemia for over one year before therapy. The exact mechanism of idiopathic hypoglycemia in children need definition, but diet and corticosteroid therapy are adequate in many. In a smaller group, subtotal pancreatectomy is necessary and reasonably successful in the restoration of normal blood glucose concentration. Therapy with growth hormone and hyperglycemic agents may make more patients responsive and reduce the number requiring surgical treatment. However, subtotal pancreatectomy is indicated in those with severe disease in whom the blood glucose levels are erratically low enough to produce neurological impairment.

ANTICONVULSANT THERAPY IN TRIGEMINAL NEURALGIA

A. Chinitz, D. F. Seelinger, and A. H. Greenhouse (University of New Mexico School of Medicine, Albuquerque)

Amer. J. Med. Sci. 252:62-67, (July), 1966.

Many types of nonsurgical treatment have been proposed for trigeminal neuralgia, but there is no convincing support that any of these methods have merit. Increasing experimental and clinical evidence indicates that diphenylhydantoin sodium (Dilantin) does effect the mechanism of pain production in this disease by inhibiting synaptic conduction in the brain stem. A new anticonvulsant, carbamazepine (G-32883 or Tegretol), also seems to be effective although occasional significant toxic reactions have been reported.

URETERAL SUSPENSION FOR PREVENTION OF URETERAL COMPLICATIONS FOLLOWING RADICAL WERTHEIM HYSTERECTOMY

T. H. Green, Jr. (226 Marlborough St., Boston)

Obstet. Gynec. 28:1-11, (July), 1966.

A technique of bilateral suspension of the ureter to the anterior division of the hypogastric artery pedicle following radical Wertheim hysterectomy for cervical cancer is described. In a consecutive series of 65 radical hysterectomies and bilateral pelvic lymphadenectomies in which this maneuver was employed, no postoperative ureteral strictures developed and only one ureterovaginal fistula occurred, a ureteral complication rate of only 1.5%. Furthermore, the transient hydroureter and hydronephrosis so often encountered in the past following the Wertheim procedure was observed in only five of these patients (7.7%), further attesting to the value of this maneuver in promoting

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Calms anxieties; controls compulsive eating.

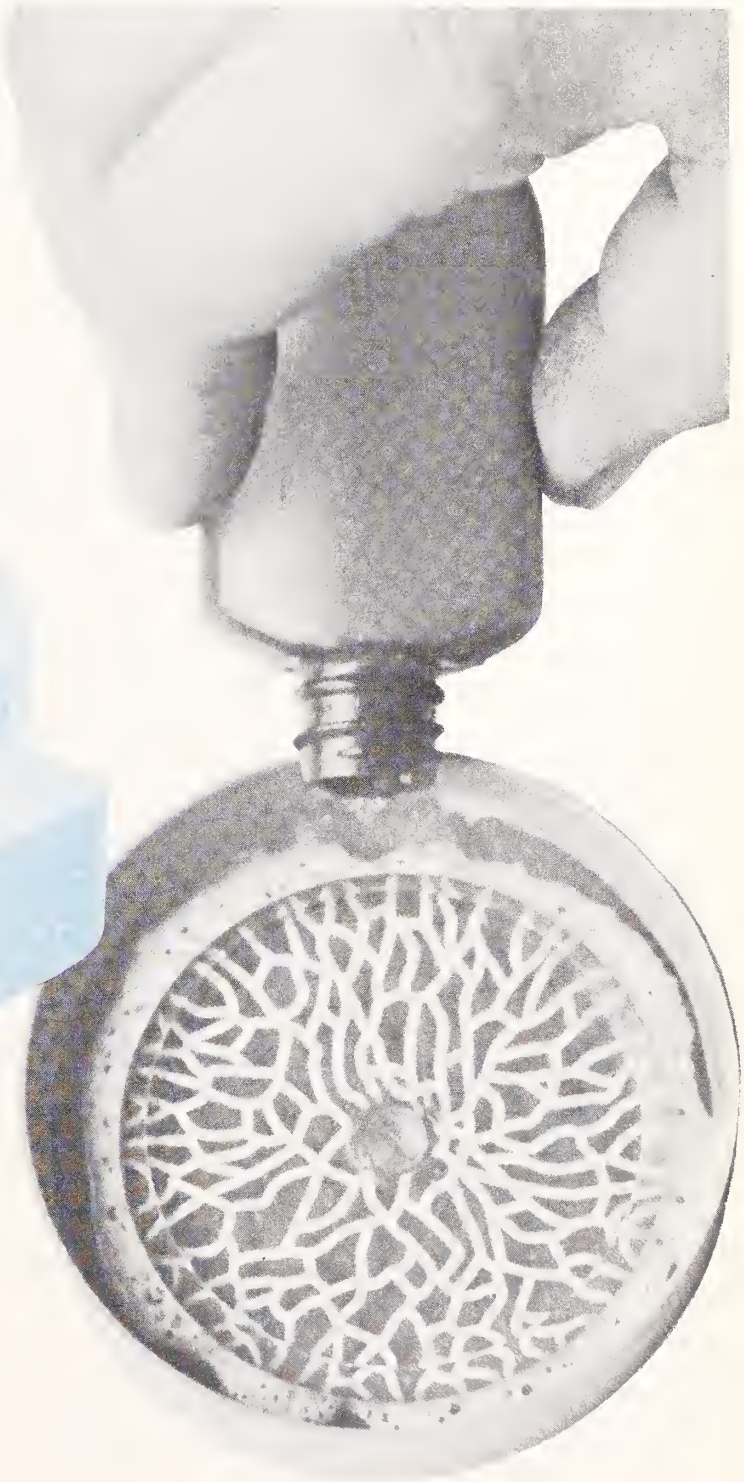
Desbutal Gradumet provides 2 drugs in 2 tablet sections, combined back to back to form a single tablet. One section contains Desoxyn to curb the appetite and lift the mood; the other contains Nembutal® (pentobarbital) to calm the patient and counteract any excessive stimulation.

Both drugs are released in an effective dosage ratio throughout the day.

controlled release

Abbott
Anorectic
Program

Not all long-release vehicles are the same. Here is why the Gradumet is different and what it means for your overweight patients.



The release action is purely physical and relies on only one factor common to every patient: gastrointestinal fluid. There is no dependence on enteric coatings, enzymes, motility, or an "ideal" ion concentration in the gastrointestinal tract.

Your patients get a measured amount of medication, moment by moment, throughout the day.

They are not subjected to ups and downs of drug release . . . or to erratic release from patient to patient . . . or to erratic release in the same patient from day to day.

That's why the Gradumet provides controlled-release as well as long release.

Perhaps you saw the Gradumet model demonstration which shows that the release is entirely physical. When fluid is added, the drug in the outer ends of the channels dissolves. As fluid penetrates deeper into the channels, there is a continuous release of medication. The rate of release is rigidly controlled by the size and number of channels.

choice of 5 strengths

Abbott
Anorectic
Program

DESOXYN Gradumet
Methamphetamine Hydrochloride in Long-Release Dose Form

5 mg. 10 mg. 15 mg.

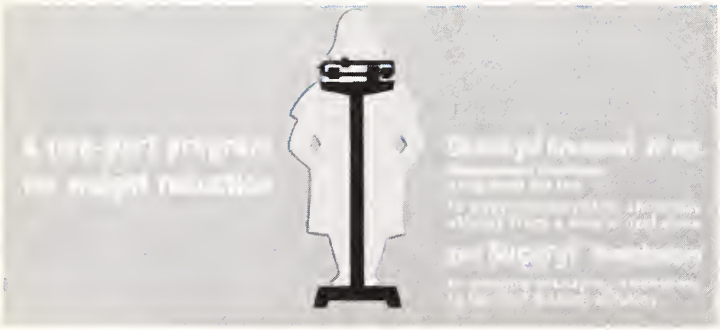
DESBUTAL 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Pentobarbital Sodium

Front Side

DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Pentobarbital Sodium

Front Side

samples available



Each sample contains 6 tablets and a filled Sucaryl® Sweetener dispenser. For a supply, write Abbott Laboratories or ask your Abbott man.

economy

Patients, in many cases, save enough to get five weeks of medication for the price of four, compared to other leading long-release anorectics.

CONTRAINDICATION: Desoxyn and Desbutal are contraindicated in patients taking a monoamine oxidase inhibitor.
PRECAUTIONS: Use with caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs or ephedrine and its derivatives. Careful supervision is advisable with maladjusted individuals.

ABBOTT

Gradumet—long-release dose form, Abbott: U.S. Pat. No. 2,987,445.
Sucaryl—Abbott brand of low and non-caloric sweeteners.

Diagnosis:

cystitis?
pyelonephritis?
pyelitis?
urethritis?
prostatitis?

in any case,
usually gram-negative*

Therapy:

two 500 mg. Caplets® q.i.d.
(initial adult dose)

NegGram®

Brand of

nalidixic acid

a specific anti-gram-negative

eradicates most urinary tract infections...

- Low incidence of untoward effects; no fungal overgrowth, crystalluria, ototoxic or nephrotoxic effects have been observed.
- "Excellent" or "good" response reported *in more than 2 out of 3* patients with either chronic or acute gram-negative infections.[1]

*As many as 9 out of 10 urinary tract infections are now caused by gram-negative organisms: E. coli, Klebsiella, Aerobacter, Proteus, Paracolon or Pseudomonas[2]... However, infections of the urethra and prostate caused by non-gonococcal gram-negative organisms are believed to be less prevalent.

Indications: Urinary tract infections caused by gram-negative and some gram-positive organisms.

Side effects: Mainly mild, transient gastrointestinal disturbances; in occasional instances, drowsiness, fatigue, pruritus, rash, urticaria, mild eosinophilia, reversible subjective visual disturbances (overbrightness of lights, change in visual color perception, difficulty in focusing, decrease in visual acuity and double vision), and reversible photosensitivity reactions. Marked overdosage, coupled with certain predisposing factors, has produced brief convulsions in a few patients.

Precautions: As with all new drugs, blood and liver function tests are advisable during prolonged treatment. **Pending further experience, like most chemotherapeutic agents, this drug should not be given in the first trimester of pregnancy. It must be used cautiously in patients with liver disease or severe impairment of kidney function.** Because photosensitivity reactions have occurred in a small number of cases, patients should be cautioned to avoid unnecessary exposure to direct sunlight while receiving NegGram, and if a reaction occurs, therapy should be discontinued. The dosage recommended for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Bacterial resistance may develop.

When testing the urine for glucose in patients receiving NegGram, Clinistix® Reagent Strips or Tes-Tape® should be used since other reagents give a false-positive reaction.

Dosage: Adults: Four Gm. daily by mouth (2 Caplets® of 500 mg. four times daily) for one to two weeks. Thereafter, if prolonged treatment is indicated, the dosage may be reduced to two Gm. daily. Children may be given approximately *25 mg. per pound* of body weight per day, administered in divided doses. The dosage recommended above for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Until further experience is gained, infants under 1 month should not be treated with the drug.

How supplied: Buff-colored, scored Caplets® of **500 mg. for adults,** conveniently available in bottles of 56 (sufficient for one full week of therapy) and in bottles of 1000. **250 mg. for children,** available in bottles of 56 and 1000.

References: (1) Based on 23 clinical papers, 1512 cases. Bibliography on request. (2) Bush, I. M., Orkin, L. A., and Winter, J. W., in Sylvester, J. C.: Antimicrobial Agents and Chemotherapy—1964, Ann Arbor, American Society for Microbiology, 1965, p. 722.

Winthrop

Winthrop Laboratories, New York, N. Y. 10016

JOHN SHAW BILLINGS HISTORY OF MEDICINE SOCIETY WILL MEET NOVEMBER 10

Dr. Lester King, senior editor of *The Journal of the American Medical Association*, will be guest speaker at the November 10 meeting of the John Shaw Billings History of Medicine Society.

His topic will be "Why Medical History?" The group meets the second Thursday of the month at the I. U. Student Union Building, Indianapolis, except for December and January when there are examinations and holidays. The social hour begins at 6 p.m., dinner is set for 6:45 p.m. and the speaker at 8 p.m.

The John Shaw Billings History of Medicine Society was founded to promote and encourage the study of the history of medicine. Membership in the society is open to all interested in the history of medicine. Attendance at lectures is open to non-members as well as members, lay persons, residents and interns.

Because of the presence of medical students, interns and residents in Indianapolis, the society has two classes of membership — students and physicians in training pay only $1.00 a year for membership. At dinner meetings, students and residents pay only half the cost of their meals; the society defrays the difference (although generally students and physicians in training come to the meeting as a guest of a senior member who accepts the charges.)

Ostomy Association "Newsletter" To Be Published on Monthly Basis

I. O., Inc. (Indiana Ostomy Association, Inc.) now publish their "Newsletter" on a monthly basis.

The "Newsletter" will contain articles written by physicians in the Indianapolis area, helpful information from ostomates as well as an objective report on new ostomy products as they are introduced.

Through the "Newsletter," physicians and other members of the medical profession can keep up with the activities of I. O., Inc. and pass the information on to their patients.

Cost of the "Newsletter" for one year is $1.00. Subscription requests should be sent to the editor, David J. Harper, 4549 Bluff Rd., Indianapolis, Ind. 46217. Checks should be made payable to I. O., Inc. To insure proper mailing, your zip code must be included in your address.

National Fire Protection Association Announces New Safety Manuals

The National Fire Protection Association announces new editions of safety manuals—"Recommended Good Practice for the Maintenance and Use of Portable Fire Extinguishers," 60 cents; "Standards for the Installation of Portable Fire Extinguishers," 60 cents; and "Hazardous Chemicals Data," $1.50. Order from the Association at 60 Batterymarch St., Boston 02110.

Indiana Physicians Named

Dr. Lester H. Hoyt, Indianapolis, was elected as vice-chairman of the AMA Section on Pathology and Physiology and Dr. Lall G. Montgomery, Muncie, was reelected as the section's delegate to the AMA.

"Rheumatoid Arthritis" Booklet Now Available for Your Patients

"Rheumatoid Arthritis" is the title of a 20-page booklet published by the Arthritis Foundation as a handbook for patients. It is designed to help arthritis sufferers and the general public to a better understanding of the nature of the disease.

Copies of the booklet are free and may be obtained from local chapters of the foundation (Indianapolis address is 615 N. Alabama) or from national headquarters at 1212 Avenue of the Americas, New York City 10036.

Drs. Snively, Westerman Win Award

Dr. W. D. Snively, Jr., and Dr. D. L. Westerman, both of Evansville, have been awarded the Honor Certificate of *Minnesota Medicine* for Excellence in Medical Writing for their article "The Clinician Views Potassium Deficit" which appeared in the June, 1965, issue of *Minnesota Medicine.*

Roche Laboratories to Reimburse Hospitals 25% of Drug Cost for Medicare Patients

Roche Laboratories will reimburse hospitals 25% of the cost of all Roche drugs used in the treatment of hospitalized patients who are Medicare beneficiaries.

This new plan supplements the Roche Indigent Patient Program through which physicians in private practice can obtain any Roche product without charge for the treatment of needy patients to whom the doctor is contributing his services.

"Tentative Standard for Inhalation Therapy" Published; Comments Invited

"Tentative Standard for Inhalation Therapy," a 28-page booklet published by the National Fire Protection Association may be obtained at the price of 50 cents.

It is the work of the Association's Committee on Hospitals headed by Dr. Carl Walter of Boston, and is published in tentative form to invite comments and discussion prior to adoption of the regular technical standards. The text deals principally with safety precautions in oxygen-enriched atmospheres. The address of the association is 60 Batterymarch St., Boston 02110.

Research Grant Announced by Indiana Tuberculosis Association

A research grant will be made by the Indiana Tuberculosis Association to a prospective researcher in a clinical or basic science project closely allied to the field of tuberculosis or related respiratory diseases.

Preference will be given to applicants within the state of Indiana. Applications must be received not later than December 31, 1966.

Continued

(now we'll get to buy the car)

"I don't know what we would've done without Blue Cross Blue Shield"

If buying a new car is a pretty big event at your house, the disappointment is big, too, when it all falls through for lack of money. And these days, an unexpected illness or accident can drain off your new car money in short order.

More than a million and a half Hoosiers guard their dreams—and their savings—with good, worry-free health care protection from Blue Cross–Blue Shield. They know Blue Cross–Blue Shield will step in and take over the health care worries, providing generous benefits at the hospital and realistic allowances to your physician.

That's why so many people say: "I don't know what we would have done without Blue Cross–Blue Shield."

If you'd like to join or have your employer consider a Blue Cross–Blue Shield group plan, phone the nearest office.

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Mutual Hospital Insurance, Inc. Mutual Medical Insurance, Inc.

Home Office: 110 N. Illinois St., Indianapolis, Indiana 46209

(One of a series of ads being used in key Hoosier newspapers)

now...introducing a new high-strength dosage form

SIGNEM

A 'MAXIMUM SECURITY' ANTIBIOTIC*

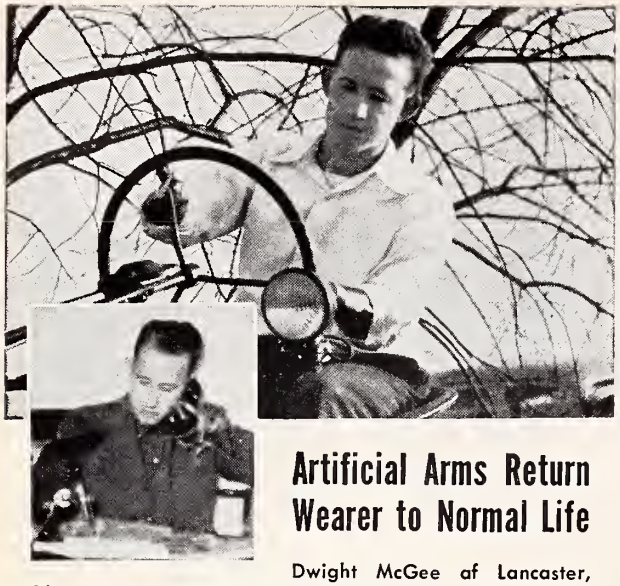
* THE BROAD RANGE DEPENDABILITY OF TETRACYCLINE
  long established as the broad-spectrum agent of first choice in a wide variety of infections
* WITH THE ADDED SECURITY OF MEDIUM-SPECTRUM REINFORCEMENT
  triacetyloleandomycin is highly active against the common 'coccal' pathogens, including certain strains of staphylococci resistant to penicillin and tetracycline
* ESPECIALLY VALUABLE IN U.R.I.
  provides decisive therapy in acute respiratory infections and other conditions in which staphylococci, streptococci or mixed flora are frequently encountered
* NOW AVAILABLE IN NEW STRENGTH FOR NEW CONVENIENCE AND ECONOMY
  Signemycin 375—high-potency capsules for simpler administration, greater patient economy

YCIN® 375

(tetracycline 250 mg. triacetyloleandomycin 125 mg.)

Indications: Indicated in the therapy of acute severe infections caused by susceptible organisms and primarily by bacteria more sensitive to the combination than to either component alone. In any infection in which the patient can be expected to respond to a single antibiotic, the combination is not recommended. Signemycin should not be used where a bacteriologically more effective or less toxic agent is available. *Triacetyloleandomycin, a constituent of Signemycin, has been associated with deleterious changes in liver function.* See precautions and adverse reactions.
Contraindications: Contraindicated in individuals who have shown hypersensitivity to any of its components. Not recommended for prophylaxis or in the management of infectious processes which may require more than 10 days of continuous therapy. If clinical judgement dictates therapy for longer periods, serial monitoring of liver function is recommended. Not recommended for subjects who have shown abnormal liver function tests, or hepatotoxic reactions to triacetyloleandomycin.
Precautions and Adverse Reactions: Triacetyloleandomycin, administered to adults in daily oral doses of 1.0 gm. for 10 or more days, may produce hepatic dysfunction and jaundice. Adults requiring 3 gm. of Signemycin initially should have liver function followed carefully and the dosage should be reduced as promptly as possible to the usual recommended range of 1.0 to 2.0 gm. per day. Present clinical experience indicates that the observed changes in liver function are reversible after discontinuation of the drug.
Use with caution in lower than usual doses in cases with renal impairment to avoid accumulation of tetracycline and possible liver toxicity. If therapy is prolonged under such circumstances, tetracycline serum levels may be advisable. In long term therapy or with intensive treatment or in known or suspected renal dysfunction, periodic laboratory evaluation of the hematopoietic, renal and hepatic systems should be done. Formation of an apparently harmless calcium complex with tetracycline in any bone forming tissue may occur. Use of tetracycline during tooth development (3rd trimester of pregnancy, infancy and early childhood) may cause discoloration of the teeth. Reversible increased intracranial pressure due to an unknown mechanism has been observed occasionally in infants receiving tetracycline. Glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and definite allergic reactions occur rarely. Severe anaphylactoid reactions have been reported as due to triacetyloleandomycin. Photosensitivity and photoallergic reactions (due to the tetracycline) occur rarely. Medication should be discontinued when evidence of significant adverse side effects or reaction is present. Patients should be carefully observed for evidence of overgrowth of nonsusceptible organisms including fungi, which occurs occasionally, and which indicates this drug should be discontinued and appropriate therapy instituted. Steps should be taken to avoid masking syphilis when treating gonorrhea.

J. B. ROERIG AND COMPANY
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-being®
New York, N.Y. 10017



Artificial Arms Return Wearer to Normal Life

Dwight McGee of Lancaster, Ohio, wearing two Hanger Arms, can write, shave, use a knife and fork, drive an automobile, and says he can do about anything an ordinary person can do. Hanger Arms are custom-made to fit the wearer's stump and his particular daily needs, and are carefully fitted by experienced Hanger fitters. Arms can be furnished with cosmetic or mechanical hand and hook.

Hanger PROSTHETICS

AIR-CONDITIONED OFFICES
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3108 Burnet Avenue, Cincinnati, Ohio 45229
446 W. Pontiac Street, Fort Wayne, Ind. 46807
416 N. Main Street, Evansville, Indiana 47711

NEWS NOTES

Continued

For further information contact: Richard N. Matzen, M.D., Chairman, Medical Research Committee, Indiana Tuberculosis Association, 30 E. Georgia St., Indianapolis, Indiana 46204.

Dr. Lamb Attends Meeting

Dr. Emmett B. Lamb, Indianapolis, attended the International Congress on Occupational Health in Vienna on September 19 to 24, as one of the two representatives of the AMA.

"Gout—A Handbook for Patients" Now Available to Physicians

"Gout—A Handbook for Patients" is a 16-page booklet published by the Arthritis Foundation for instruction of the layman. It discusses the cause and symptoms of the disease and the treatment for it in a series of questions and answers.

Copies of the booklet may be obtained from the Indiana Chapter of the Arthritis Foundation, 615 N. Alabama, Indianapolis, or from the national headquarters at 1212 Avenue of the Americas, New York City 10036.

Dr. Garvin Promoted

Dr. Donald B. Garvin, a 1954 graduate of I.U. School of Medicine, who practiced in Brazil, Indiana for nine years before joining McNeil Laboratories, has been appointed assistant director of clinical investigation for McNeil. He is a member of the Clay County Medical Society.

A hospital for the diagnosis and treatment of psychiatric illness

WABASH VALLEY HOSPITAL

(a not for profit corporation)

2900 North River Road (State Road 43 north)
West Lafayette, Indiana, Phone 317-743-3841

Active Psychiatric Staff	(Phone)
W. R. VanDenBosch, M.D.	447-6404
Joe M. Martin, M.D. Edgar C. Stuntz, M.D. David L. Evans, M.D.	743-1809
Limited private practice	
John H. Wilms, M.D. F. H. Spurlock, M.D. Alfred R. Heasty, M.D.	92-2441

Robert K. Jones, Ph.D.
Clinical Psychologist

Mrs. Margaret Keedy, A.C.S.W.
Psychiatric Social Worker

Elizabeth J. Snyder, R.N.
Director of Nursing Service

James Jones, B.P.E.
Director of Activity Therapy

Donald R. Kinzer, Hospital Administrator

Admissions are arranged through referral to any active staff psychiatrist.

All general medical and surgical specialties in the community are available through physicians on the open consulting staff.

Indiana Doctors New Fellows

The American College of Chest Physicians at a recent annual meeting inducted as Fellows the following physicians from Indiana: Dr. William H. Atwood, Elkhart; Dr. Jack T. Collins, Bluffton; Dr. Ramon S. Dunkin, Indianapolis; Dr. Wendell L. Edwards, Indianapolis; and Dr. Gene R. Hay, Michigan City.

New Booklet Published by U.S. Department of Labor

"Training Health Service Workers: A Critical Challenge" is the title of a booklet published by the U.S. Department of Labor as an aid in the recruitment of workers into the health services.

It is estimated that the nation must recruit 10,000 workers per month for the next ten years to provide necessary health services. Copies of the booklet may be obtained by writing the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402.

School Health Report Published By American Academy of Pediatrics

School health programs and information on all essential school health matters are discussed in a report published by the American Academy of Pediatrics.

Subjects covered include the physician's function in school health appraisal programs, school health as related to adolescents and handicapped children, school failure, attendance problems, sports medicine, management of emergencies, health of school personnel, health education for school children and education of physicians in school health. Single copies may be obtained from the academy at 1801 Hinman Ave., Evanston, Illinois 60204, for $2.00.

Dr. Wing Named AMA Representative

Dr. Herman Wing, Gary, alternate councilor-elect from the 10th District, has been designated as the American Medical Association representative to the International Symposium on Rehabilitation in Neurology in Prague, Czechoslovakia, September 20-23.

Dr. Wing will also represent the AMA at the first Soviet American Conference on Physical Medicine and Rehabilitation at Moscow, Sept. 24-October 1st.

American College of Chest Physicians Announces Cash Awards for Essays

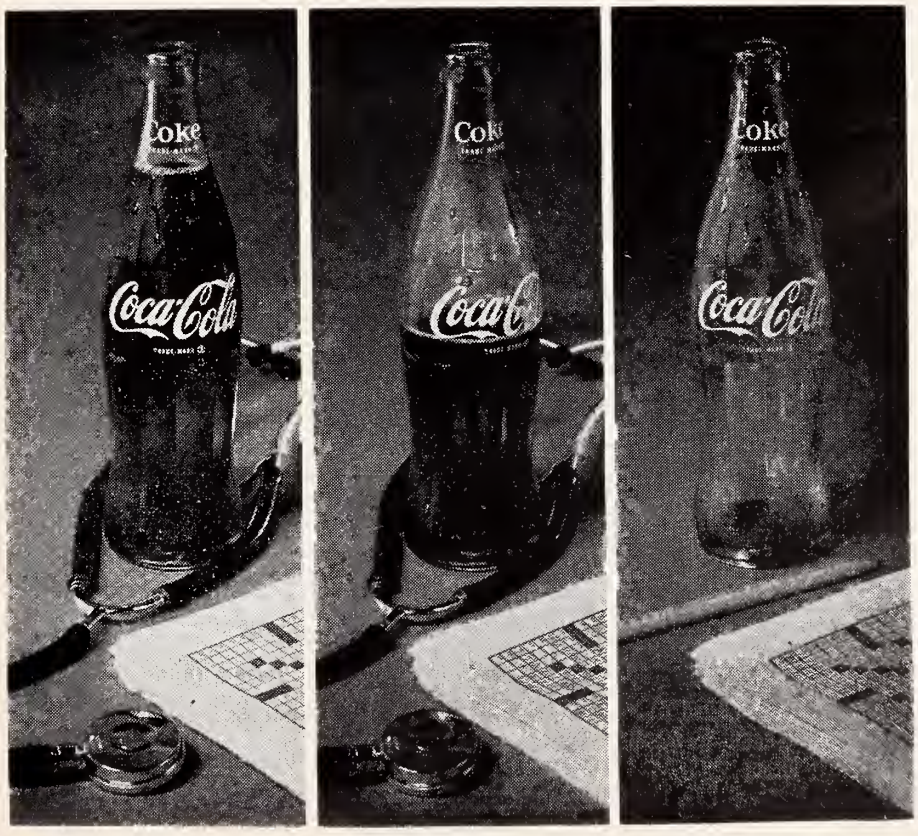
The American College of Chest Physicians is offering three cash awards to the winners of an essay contest. The contest is open to undergraduate medical students throughout the world.

The essays are to be written on any phase of the diagnosis and/or treatment of diseases of the heart and lungs, and may concern research or be written as review articles. Complete information may be obtained by writing the college at 112 E. Chestnut St., Chicago 60611.

Explanatory Folder on "Plastic Surgery" Available to Doctors for Patients

An explanatory folder on "Plastic Surgery" has been published by the American Academy of Facial Plastic and Reconstructive Surgery for instruction of the public-at-large.

Physicians may obtain a supply of these folders for distribution to patients by writing Dr. Jack R. Anderson, 322 California Company Bldg., 1111 Tulane Ave., New Orleans 70112. They are sold at cost of $3.00 per 100. ◄



11:47 pm 11:53 pm 12:06 am

The meaningful pause. The energy it gives. The bright little lift. Coca-Cola with its never too sweet taste, refreshes best. Helps people meet the stress of the busy hours. This is why we say things go better with Coke

TRADE-MARK

INDIANA STATE BOARD OF HEALTH

MONTHLY REPORT—August, 1966

Disease	Aug. 1966	July 1966	June 1966	Aug. 1965	Aug. 1964
Animal Bites	1038	967	1476	890	848
Chickenpox	53	75	196	38	28
Conjunctivitis	158	85	131	127	81
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	44	44	37	89	51
Gonorrhea	474	338	497	357	351
Impetigo	221	130	86	244	240
Infectious Hepatitis	21	30	28	43	24
Infectious Mononucleosis	31	45	48	27	15
Influenza	137	112	360	194	283
Measles (Rubeola-Rubella)	94	322	1241	123	133
Meningitis, Meningococcal	7	1	8	1	3
Meningitis, Other	4	4	6	5	4
Mumps	59	81	309	70	158
Pertussis (Whooping Cough)	23	32	5	11	29
Pneumonia	136	153	419	112	118
Poliomyelitis	0	0	0	0	1
Streptococcal Infection	265	238	513	321	345
Syphilis					
Primary & Secondary	13	9	9	3	4
All Other Syphilis	94	86	119	88	109
Tinea Capitis	12	5	4	7	6
Tuberculosis (Active)	83	83	102	114	110

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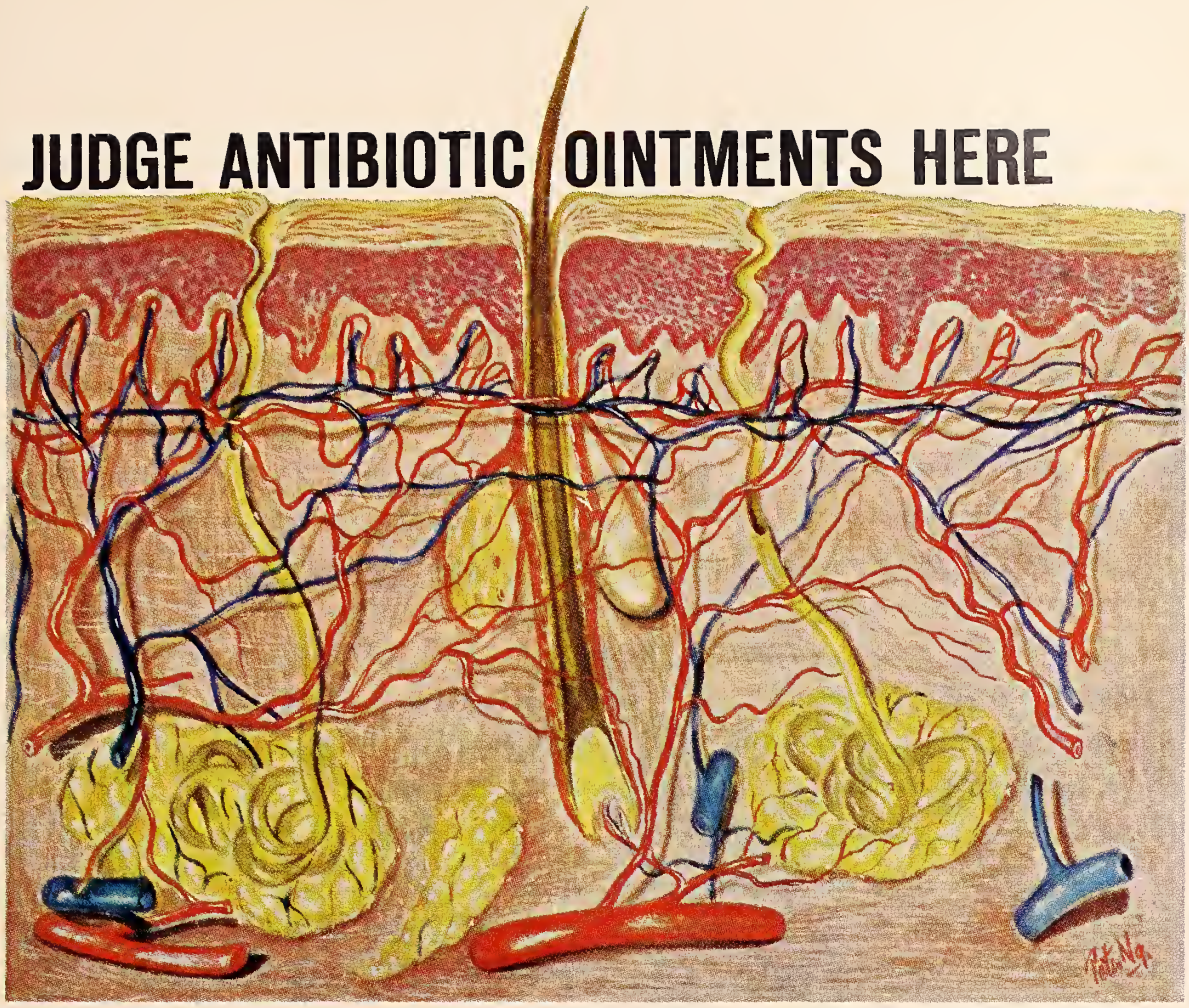

Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Antibiotic Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and rarely sensitizes.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'®

brand

POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

new

a new formulation that relieves pain in tension headache and neuralgia

Dialog is a combination of 15 mg allobarbital and 300 mg acetaminophen. Allobarbital, a proven barbiturate, provides desirable sedation in patients experiencing pain and discomfort. Acetaminophen is a nonsalicylate analgesic-antipyretic, well tolerated and useful in a wide range of mildly painful and febrile conditions.

Dialog is well tolerated, even by those sensitive to aspirin. It is nonirritating to the gastrointestinal tract and, in recommended dosage, has no adverse effects on the kidneys.

- Raises the pain threshold
- Suppresses the pain-producing mechanism
- Reduces emotional tension

2/3449 MK-3

for tension headache

Dialog™
(allobarbital and acetaminophen CIBA)

Indications: For relief of pain and discomfort of simple headache; neuralgia, myalgia, and musculoskeletal pain; dysmenorrhea; bursitis; sinusitis; fibrositis. Also indicated to reduce fever and to relieve discomfort due to respiratory infections, influenza, and other febrile conditions.

Contraindication: Not recommended during pregnancy.

Caution: May be habit-forming. Do not use in patients sensitive to barbiturates or in those with moderate to severe hepatic disease.

Side Effects: Nausea, transitory dizziness, rash. Overdosage of allobarbital produces symptoms typical of acute barbiturate excess.

Dosage: *Adults:* 1 or 2 tablets every 4 hours. Not to exceed 8 tablets in 24 hours. *Children 6 to 12:* ½ to 1 tablet every 4 hours. Not to exceed 4 tablets in 24 hours.

Supplied: *Tablets* (white, scored), each containing 15 mg allobarbital and 300 mg acetaminophen; units of 3 bottles of 30.

For your convenience—prescription-size bottle of 30.

CIBA Pharmaceutical Company, Summit, N.J.

C I B A

American Medical Women's Association Will Have Annual Meeting November 2-5

The American Medical Women's Association will hold its annual meeting in Washington, D. C., at the International Inn, on November 2 to 5.

In addition to the scientific program which will highlight a symposium on "Sexual Problems in Clinical Practice," the meeting will include a private tour of the White House, a dinner-theater party, and the Association's House of Delegates.

Third Pan American Cancer Cytology Congress Will Meet May 7-11, 1967

The Third Pan American Cancer Cytology Congress will meet at the Waldorf Astoria in New York City, May 7 through 11, 1967.

Clinicians, cytologists, pathologists and research scientists are invited to attend. Full particulars may be obtained from Dr. J. Ernest Ayre, 115 E. 69th St., New York City 10021.

ISMA Members Invited to Sectional Meeting of American College of Surgeons

Members of ISMA are invited to attend a sectional meeting of the American College of Surgeons at the Broadmoor Hotel in Colorado Springs, February 15 to 17, 1967.

Technics of handling problems encountered in day-to-day practice will be discussed. Panel discussions, special reports, "How-I-do-it" clinics and medical films will concern acceptable and new treatment.

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- Do your bookkeeping
- Spend our time in the purchase of your cars

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MONARCH
31 W. ELEVENTH ST. 635-4219

There will be a similar sectional meeting in New York City, February 27 to March 2. Inquiries should be addressed to Dr. Woodrow L. Pickhardt, 55 E. Erie St., Chicago 60611.

Socio-Economics of Health Care National Congress January 22-23, 1967

Socio-Economics of Health Care will be discussed at a national congress by the same name to be held in Chicago on January 22 and 23, 1967. The Congress is the first of its kind and will be sponsored by the AMA Council on Medical Service and the AMA Division of Socio-Economic Activities.

Scheduled at the Palmer House, the meeting will bring together authorities from medicine, health care administration, social science, education, community planning and others to discuss organization, delivery and financing of health care services. For information and registration details write the AMA Division of Socio-Economic Activities, 535 N. Dearborn, Chicago 60610.

Postgraduate Course on Pulmonary Function in Health and Disease

A postgraduate course on Pulmonary Function in Health and Disease will be conducted by the Louisiana Thoracic Society in New Orleans on November 28 through December 1.

Tuition is $100 for physicians who are not members of the American Thoracic Society, $75 for members, $25 for nurses and technicians. Residents will be enrolled free upon acceptance by the course committee. The program of instruction may be obtained by writing the Society at Suite 407, 305 Baronne St., New Orleans 70112.

American Academy of Forensic Sciences Annual Meeting in Honolulu

The American Academy of Forensic Sciences will hold its annual meeting in Honolulu at the Princess Kaiulani Hotel from February 20 to 25, 1967.

Write to Dr. Alvin V. Majoska, 1455 S. Beretania St., Honolulu 96814, for details of travel and of sightseeing trips both before and after the convention. The scientific program will be published later and can be obtained by writing Dr. Majoska.

University of Chicago Hospitals and Clinics "Frontiers of Medicine" Series

The University of Chicago Hospitals and Clinics will present their second "Frontiers of Medicine" series for the practicing physician.

The presentation of recent developments in various disease will be in eight afternoon sessions on the second Wednesday of each month from October, 1966 through April, 1967. Members of ISMA are invited to attend. For full details write Miss Dorothy Taylor, 950 E. 59th St., Chicago 60637.

Postgraduate Study Programs At the University of Vienna

The American Medical Society of Vienna announces its continued sponsorship of postgraduate study programs at the University of Vienna Clinics. The club headquarters of the Society are located in the University section of Vienna and are close to the University Clinics. The club rooms and the extensive library of the Society are the study center for English-speaking doctors. Hotel accommoda-

tions are available in Vienna in all class prices.

Further information may be obtained by writing to Dr. M. A. Kline, Executive Secretary of the American Medical Society of Vienna, Universitatsstrasse 11, Vienna 1, Austria.

Indiana Conference on Social Welfare 75th Annual Conference

The Indiana Conference on Social Welfare will hold its 75th annual conference at the Claypool Hotel, Indianapolis, on November 9 to 11.

All citizens are invited to attend. Write the Conference, c/o English Foundation Bldg., 615 N. Alabama St., Indianapolis 46204 for program and advance registration blank.

National Conference on Air Pollution Will Be December 12-14

The National Conference on Air Pollution will be conducted at the Sheraton-Park Hotel in Washington, D. C. on December 12 to 14 by the U. S. Public Health Service. It is open to all interested physicians.

Write the Executive Secretary, National Conference on Air Pollution, Public Health Service, Washington, D. C. 20201.

Postgraduate Course on Treatment Of Fractures November 28-December 1

A comprehensive postgraduate course on the treatment of fractures will be held in Cleveland under the sponsorship of the American Academy of Orthopaedic Surgeons at the Hollenden House from Nov. 28 to Dec. 1 inclusive.

The registration fee is $75.00. For complete details write Dr. George E. Spencer, Jr., 2065 Adelbert Road, Cleveland 44106.

Harvard Medical School Offers Postgraduate Course on Cancer Treatment

Harvard Medical School will conduct a postgraduate course in Diagnosis and Treatment of Cancer on November 9, 10 and 11, at the Massachusetts General Hospital.

Attendance will be limited to 55. The fee is $105. Apply to Assistant Dean, Courses for Graduates, Harvard Medical School, 25 Shattuck St., Boston 02115.

American Cancer Society Will Conduct Annual Scientific Session May 3, 1967

The American Cancer Society will conduct its annual scientific session at the Sheraton-Dallas Hotel in Dallas on May 3, 1967. The theme of the meeting will be "Current Concepts in Etiology and Diagnosis of Cancer."

Members of ISMA are all invited and are urged to attend. There is no registration fee. Copies of the program may be obtained by writing the Society at 219 E. 42nd St., New York City 10017.

Symposium on Skin Diseases Common To Man and Animal will be November 2

A symposium on Skin Diseases Common to Man and Animals will be held on November 2, in Palm Springs, California, at the El Mirador Hotel.

Co-sponsors are the Committee on Cutaneous Health and Cosmetics of the American Medical Association and the American Animal Hospital Association. Fee for registration and lunch is $10.00.

Programs and registration forms may be obtained by writing the AMA Committee at 535 N. Dearborn, Chicago 60610.

Laryngology, Bronchoesophagology Course October 31 to November 12

The Department of Otolaryngology of the Illinois Eye and Ear Infirmary and the College of Medicine of the University of Illinois at the Medical Center, Chicago, will conduct a postgraduate course in laryngology and bronchoesophagology from October 31 through November 12.

This course is limited to fifteen physicians and will be under the direction of Paul H. Holinger, M.D. It will be held largely at the new Illinois Eye and Ear Infirmary, 1855 West Taylor Street, Chicago, and will include visits to a number of Chicago hospitals. Instruction will be provided by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures.

Interested registrants will please write directly to the Department of Otolaryngology, College of Medicine of the University of Illinois at the Medical Center, P. O. Box 6998, Chicago, Illinois 60680.

Course in Gastroenterology Offered in Philadelphia in October

The annual postgraduate course in Gastroenterology of the American College of Gastroenterology will be given at the Bellevue Stratford in Philadelphia on October 27 to 29.

The subject matter to be covered, from the medical as well as the surgical viewpoint, will be essentially the diagnosis and treatment of gastrointestinal diseases and comprehensive discussions of diseases of the esophagus, stomach, pancreas, liver and gallbladder, small intestine and colon. A session on instrument techniques will be held at the Albert Einstein Medical Center.

For enrollment and more information write American College of Gastroenterology, 33 W. 60th St., New York City 10023. ◄

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Corcoran, A. C.: The choice of drugs in the treatment of hypertension. In: Drugs of Choice 1966-67, W. Modell, Ed., St. Louis, C. V. Mosby Company, 1966, p. 417.

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Annual Meeting Dates of Professional Medical and Allied Organizations

AMERICAN MEDICAL ASSOCIATION CLINICAL MEETING
Date November 27-30, 1966
Place Las Vegas, Nevada

INDIANA HOSPITAL ASSOCIATION
Date Nov. 2-4, 1966
Place Marott Hotel, Indianapolis

NORTHERN INDIANA PSYCHIATRIC SOCIETY
Date Fourth Wednesday of every month, September through June
Place For location and program, inquire Beatty Memorial Hospital, Westville

INDIANA NEUROPSYCHIATRIC ASSOCIATION
Date Second Wednesday of the month, October through May, excluding December
Place The Athenaeum, Indianapolis

AMERICAN COLLEGE OF SURGEONS, INDIANA CHAPTER
Date April 7-8, 1967
Place Morris Inn, Notre Dame University, South Bend

INDIANA ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY
Date May 4-6, 1967
Place Stouffer Inn, Indianapolis

INDIANA PHARMACEUTICAL ASSOCIATION
Date July 18-20, 1967
Place French Lick Sheraton Hotel, French Lick

INDIANA ACADEMY OF GENERAL PRACTICE
Date May 3-4, 1967
Place Murat Temple, Indianapolis

INDIANA STATE MEDICAL ASSOCIATION CONVENTION
Date October 9-12, 1967
Place French Lick, Indiana

INDIANA PUBLIC HEALTH ASSOCIATION
Date April 26-27, 1967
Place Indianapolis

INDIANA OBSTETRICAL AND GYNECOLOGICAL SOCIETY
Date November 2, 1966
Place Howard Johnson's (downtown), Indianapolis

INDIANA ROENTGEN SOCIETY
Date May 7, 1967
Place Indianapolis

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Deaths

Lloyd H. Davis, M.D.

Dr. Lloyd H. Davis, a native of Crawfordsville who practiced medicine there for 15 years, died August 18 at Shoreham, Vt.

Dr. Davis, 77, was graduated from the Northwestern University School of Medicine in 1922 and practiced in Crawfordsville from 1925-40. He was a Senior Member of ISMA, specialized in geriatrics and was a member of the Jefferson-Switzerland County Medical Society.

C. M. Gibbs, M.D.

Dr. C. M. Gibbs, 93, Greenfield physician for 53 years, died August 31 in Memorial Hospital.

Graduated from the I. U. School of Medicine in 1900, Dr. Gibbs retired in 1953. He served in World War I as a captain in the U. S. Army Medical Corps and three terms as Hancock County Coroner. He was a member of the Hancock County Medical Society.

Edward G. McArdle, M.D.

Dr. Edward G. McArdle, Fort Wayne physician, died Sept. 6 at St. Joseph's Hospital there.

Dr. McArdle, 55, was a general practitioner in Fort Wayne for 25 years and had served as a member of the Fort Wayne Board of Health. He was graduated from the I. U. School of Medicine in 1935 and served in World War II from 1942-45. He was a member of the Allen County Medical Society.

Arthur E. Newland, M.D.

Dr. Arthur E. Newland, 72, Bedford physician and surgeon for 38 years, died Aug. 27 in Dunn Memorial Hospital.

Graduated from the I. U. School of Medicine in 1923, Dr. Newland began the practice of medicine in Hartford City and went to Bedford in 1926. He practiced there until 1964 when he gave up his practice to become associated with another physician in Puerto Rico. He practiced there until illness forced his return home. Dr. Newland specialized in surgery during much of his career. He was formerly a member of the Lawrence County Medical Society. ◄

THE COUNCIL

July 17, 1966

The Council of the Indiana State Medical Association convened for its summer meeting at 10:00 a.m., Sunday, July 17, 1966, in the headquarters office, 3935 North Meridian Street, Indianapolis, with Dr. E. T. Edwards, the chairman, presiding.

Roll call showed the following present:

Councilors:

First District—P. J. V. Corcoran, Evansville
Second District—E. T. Edwards, Vincennes
Joe E. Dukes, Dugger, councilor-elect
Third District—Donald M. Kerr, Bedford
Fourth District—Robert M. Reid, Columbus
Jack E. Shields, Brownstown, alternate (also AMA delegate)
Fifth District—V. Earle Wiseman, Greencastle
A. W. Cavins, Terre Haute, alternate
Sixth District—William R. Tindall, Shelbyville
Seventh District—John O. Butler, Indianapolis, alternate-elect
Eighth District—Donald R. Taylor, Muncie
Paul W. Sparks, Winchester, alternate
Ninth District—Peter R. Petrich, Attica
Clarence G. Kern, Lebanon, alternate
Tenth District—Lowell H. Steen, Whiting
Eleventh District—Lowell J. Hillis, Logansport
Twelfth District—Milton F. Popp, Fort Wayne
Thirteenth District—Not represented

Officers:

Kenneth O. Neumann, Lafayette, president
Eugene S. Rifner, Van Buren, president-elect
Ottis N. Olvey, Indianapolis, treasurer
Lester H. Hoyt, Indianapolis, asst. treasurer

Journal:

Frank B. Ramsey, Indianapolis, editor

Executive Committee:

G. O. Larson, LaPorte, member

Guests:

Harold C. Ochsner, Indianapolis, AMA delegate
Guy A. Owsley, Hartford City, AMA delegate
Dwight W. Schuster, Indianapolis, AMA alternate delegate, and chairman, Commission on Legislation
A. C. Offutt, Indianapolis, State Health Commissioner
Lester D. Bibler, Indianapolis, AMA Trustee, and chairman, Student Loan Committee

Staff:

Robert J. Amick, field secretary
Howard Grindstaff, field secretary
Kenneth W. Bush, administrative assistant
James A. Waggener, executive secretary

By consent the minutes of the meeting of the Council held April 16, 1966, were approved as printed in the July, 1966 Journal.

On motion of Drs. Petrich and Steen, approval of the minutes of the June 12, 1966 Council meeting was deferred until the meeting of the Council on October 10, 1966, at French Lick. In the meantime several corrections are to be made in these minutes.

Reports of Councilors

DR. EDWARDS, Second District, reported that Dr. Joe E. Dukes had been elected councilor of the Second District. He also announced the resignation of Dr. Philip T. Holland, alternate councilor of the Second District.

At the district meeting on June 9, 1966, it was agreed that the host county (Greene) for the next district meeting would elect the district president, but up to this time no word has been received from Greene county on this matter.

DR. KERR, Third District, read a letter from a physician in his district who had appealed to the Council for adjudication of his membership in the local county medical society.

DR. BUTLER, alternate councilor-elect, Seventh District, in the absence of Dr. Donato, councilor, reported that at the Seventh District meeting on May 4, 1966, Dr. Glen Ryan was elected as nominee for membership on the Blue Shield Board.

DR. STEEN, Tenth District, announced that Dr. Herman Wing, Gary, had been elected alternate councilor to replace Dr. Lee Trachtenberg, effective January 1, 1967.

Thirteenth District — September 28 was reported as the date for the 1966 Thirteenth District meeting, at Elkhart.

Reports of Officers

DR. KENNETH O. NEUMANN, President: Mr. Chairman, gentlemen. It hasn't been too long since I last reported to you and since that time I have attended several meetings including the week-long AMA session in Chicago. I am pleased to report that the meeting in Chicago indicated, to me at least, a resurgence of the philosophy in the AMA House of Delegates that I believe is more closely in line with what we think. I indicated to you at our last meeting that a change in this direction seemed apparent as I attended these other state meetings and I believe this was evident at the AMA meeting. I'm sure the AMA delegates will report to you further along this line.

We are most pleased by the unanimous election of Jack Jones as Vice-President of the AMA and as a bonus, Guy Owsley's election to the Council on Medical Services by a decisive margin was most gratifying. These elections are a recognition of these men and a lot of hard work by this delegation. The delegation accused me of "starving" them in Chicago. I think they returned to their normal state of nutrition in a hurry but I think my statement of "a hungry delegate is a working delegate" is correct and I suppose you can add this on to the complaints I received of the platform "no booze and raise the dues" two years ago. Seriously though, I think the AMA delegation did an excellent job.

I made it my business to go around to the various reference committees and in these reference committees, our delegates, officers and alternate delegates were on their feet, were talking and were making valid points. This is what we have been encouraging. The same thing occurred with the delegates on the floor and I think this is fine. I think this is something our delegates should do more of because this brings us a certain amount of attention and also I think we made valid points.

For the coming annual session in French Lick I requested that four of the members of the Council serve as hosts for the presidents of the various medical associations who will be at this meeting. I would like to get this matter straightened out because the headquarters can then prepare letters to send to these individuals and you will thus have personal contact. Then when these men come to the meeting, they'll have somebody to take them around and to show them how we work. Now, for some of you who know some of these individuals — I'm going to read off the men who presumably would be here at that time and perhaps you can select someone that you like. From Kentucky, I presume Dr. Robert L. Pennington, who is now president-elect, will attend the meeting. Does anyone know Dr. Pennington? He is from New London. Doctor Owsley will be his host then.

Now from Michigan, I presume it will be Allen Payne from Grand Rapids; he is president-elect, and I imagine will be president. Doctor Hoyt, would you like to be his host? (Yes). From Illinois, we will probably have either Caesar Portes from Chicago or Doctor DuPee from Quincy. Probably Caesar will come down because he enjoyed our last meeting; Doctor Ochsner will be host to him. Larry Meredith from Ohio. Doctor Petrich will be host and also Doctor Steen and Doctor Kerr. Wisconsin is Doctor Frank E. Drew who is president and Doctor Keith who is president-elect. One of the councilors will be host to these men.

I'm in the process of appointing reference committees and I am making a deliberate effort to keep off of the reference committees, officers, councilors, alternate councilors and delegates to the AMA in order that each of you individuals may attend the various committee meetings and give them the benefit of your knowledge. If any of you have any individuals in your district who you think would make good appointees to reference committees and who are interested

in working, I would appreciate receiving those names from you today. It's my intention to make some of these reference committees somewhat controversial because I feel that in the past four or five years, in some instances, these committees have been somewhat "stacked," if I may use that word. I think somehow we need to get some new blood into some of these reference committees and I am hoping that we can put some old heads on these and get a couple of new ones in order to get the "gospel" out a little bit.

If any of you have any suggestions, if you would jot them down; we do need some new faces and we would like to get some more people interested in working on the organization.

Mr. Chairman, there are other things that will come up later in the morning that I would like to comment about.

I would like the Council's concurrence in the action that we took in Chicago because I think this matter has to be settled.

DR. EUGENE S. RIFNER, president-elect: I'd like to make a few comments about the AMA meeting. Of course the wins that we have been commending the delegation for were fine. I thought there was one other thing that perhaps was a bit more heartening. This is the fact that the House of Delegates stood on their hind legs and were not talked out of their position at the end of the meeting when they stood up and passed the Oregon resolution and did not choose to reconsider it, which was very similar to the resolution we passed here concerning radiology and pathology. I was sure early in the meeting and from past experience that this would get watered down, thrown out, and be valueless, only to find out that there were many scared people there, and it's the first time I've seen this much backbone in the House of Delegates.

Kenny remarked this was a hungry delegation, and a hungry delegation works. I might also state that under exceptional leadership they were a united delegation and this is why they won. It's because they were united in purpose and not at cross-purposes at all. The delegates conducted themselves as a team, not as individuals. As I have watched the few AMA meetings that I have attended, it would seem to me that there has evolved in the last year or two, organization of the delegation, and by the delegation. I mean the delegates and the Executive Committee, the entire delegation from Indiana. It would seem to me you might take under consideration, not today, of the possibility of laying down a Rules of Order for that delegation so that this unity shown at the last meeting will not be lost as officers are lost but can be maintained so that new men will not have to wonder how this was done.

I would also like to inform you that I have been appointed to the Regional Medical Advisory Group. I received a letter dated July 14 from Professor Hickam stating that this was true. I'm sure that this comes as the president-elect and next year's president, to be represented on that group. As usual, they mailed this out so that I got it on Saturday telling me there would be a meeting at 2 o'clock on Thursday. This, I hope to correct with the Dean and the committee, but I think there will be times when we'll need considerable guidance as to what is proper under that group. Further than that, I have nothing else to report since our last meeting.

DR. OTTIS N. OLVEY, treasurer, reported as follows (all figures as of June 30, 1966):

Balance due on headquarters building	$20,000.00
Balance due on Pennsylvania Street properties	31,375.00

Cash Report

		Total
General Fund:		
Checking	$ 23,423.67	
Savings	66,578.05	
Bills	100,000.00	
Securities	50,000.00	
		$240,001.72
Obligations:		
AMERF 1966 dues	19,205.00	
Reserves	61,642.86	80,847.86
Total of cash and securities		$159,153.86

Summary of All Funds:

		Total
General Fund:		
Cash	$ 23,423.67	
Investment securities	216,578.05	$240,001.72
Journal Fund:		
Cash	7,711.95	7,711.95
Medical Defense Fund:		
Cash	2,697.93	
Investment securities	35,000.00	37,697.93
Building Fund:		
Cash	843.18	843.18
Building Fund:		
Auxiliary donation	3,777.71	3,777.71
Student Loan Fund (old):		
Cash	1,241.01	
Investment securities	7,800.00	9,041.01
Kitchen Fund:		
Investment	1,742.18	1,742.18
Total cash	$ 39,695.45	
Total investments	261,120.23	
TOTAL		$300,815.68

DR. FRANK B. RAMSEY, Editor of *The Journal:* You remember at a previous meeting we discussed publication of the roster in the fall so that it would include as many of the new members as possible. Since that time we have studied the implementation of this and we find that there are three issues in *The Journal* each year that are particularly large and difficult to put together. One of these is the roster issue, another is the convention issue and the third one is the December issue, which must carry all the official minutes from the annual meeting.

If we move the roster issue to October-November, it would put three of our biggest and most difficult issues almost in succession within a period of four months. The office personnel say this may be possible but it is extremely difficult and as a substitute for this I'd like to get consent to publish the roster in June as we have been and then publish a little annex which would include occasional omissions we have in the June number and also the new members and publish this in October or November.

Dr. Maple of Sullivan, retired from practice for some time, has written me that he is now too feeble to continue as necrologist. He has recommended that this duty could be handled by the staff in *The Journal* office. Mr. Waggener and I have talked to the girls and they are not anxious to do it, of course, but they have no serious objection to it and I'm sure they could handle it. Dr. Maple has very kindly written out instructions as to how he has handled the records and *The Journal* staff is prepared to take over unless there is some objection. I'd like to have the consent of the Council for Jim to write a special letter to Dr. Maple to thank him for all of the fine work he has done. It's sort of a thankless assignment and he has done a real fine job on it.

(It was taken by consent that a letter should be written to Dr. Maple in recognition of his interest and his fine work as necrologist of the association and thanking him for his long and efficient service.)

Our finances are in good shape. As of July 1, we have already collected 83% of what we expected to take in revenue and we have spent only 70% of what we expected to spend on the printing bill. We're about $10,000 in excess in revenue now, which is about what we will need to carry the convention issue which is an expensive issue and to withstand the summer slump in advertising revenue which we have always had.

There is one last thing I would like to speak about. All of the journals in the advertising bureau are trying to develop a little reaction on the part of the association members to advertising. We're trying to develop a system of writing letters or notes to advertisers to let them know that their advertisements have been seen and appreciated. Several in Chicago say it is practically impossible to lose a drug advertiser who receives only a few pieces of mail every month from each one of the journals.

We have instituted in *The Journal* office a custom of having Mrs. Stahl write a letter to some ten or twenty association members taken in rotation and scattered over the state each month to ask them to look through the current issue of *The Journal* and write the advertiser whose advertisements they are attracted to, and in addition to that, I would like to suggest that all of the officers and each councilor do this same thing, not just one month, but habitually every month. It isn't a thing that would take long and could be hurriedly written on a prescription note. It isn't necessary to know the man's name, you can write to the president of the company or the advertising manager. These are things that will very greatly strengthen our advertising and make us good friends.

Chair: Has there ever been in any of the journals of the 50 states a page the doctors can tear out already directed to these companies, sign it and put it in an envelope? Anything like this?

Dr. Ramsey: Not that I know of but that is the best way of doing it. Some of the companies have a coupon which is a request for literature or samples. Actually that's what the advertisers like to get, a lot of coupon response.

Delegates to the AMA: Drs. Ochsner, Owsley and Shields discussed the actions taken by the AMA House of Delegates at its meeting in Chicago in June. (For complete report, see pages 930-934, August, 1966, *Journal*).

DR. LESTER D. BIBLER, member of the AMA Board of Trustees, reported on actions of the Board of Trustees at the Chicago meeting, as follows:

(1) AMA-TV spot-films are being reviewed and their distribution will be curtailed unless they are kept on a high plane; that is, sponsors should have ethical paramedical, medical or pharmacy background.

(2) Question of recommendations for nominees for national committees of the AMA. The final recommendations come through the various agencies, particularly the Council carries a lot of weight with its recommendations. Recommendations from the state associations should go to the members of the nominating committee of the Board of Trustees as well as to the Council involved.

(3) Emphasized that separate billing is legal according to the Medicare bill.

(4) *Health Manpower survey.* Dr. Dwight L. Wilbur, member of the Board of Trustees, is on the national Manpower Board.

(5) Importance of having AMA men from Indiana on National Blue Shield Board and other national boards.

(6) Regulation No. 5 was discussed. (Dr. Bibler presented a copy of the suggested changes that had been reviewed by Dr. Blasingame and suggested that ISMA reproduce these for distribution. Dr. Bibler also suggested that a draft of the criteria for determining reasonable charges might well be distributed as a matter of information.)

(7) *AMA Disability Insurance Program.* In accordance with its contract, this program will be continued for another year. The Board of Trustees is looking for another carrier to assume the responsibility of future contracts and the continuance of old contracts.

Matters from Committees and Commissions

1. *Council Liaison Committee with Blue Shield.*

a. Dr. Steen, chairman, discussed the difficulties encountered with the card form used by Blue Shield for billing procedures due to the fact that many are now using computerized billing. Other commercial companies have agreed to accept the standard insurance form which conforms to the standard form provided by the Health Insurance Council. Blue Shield says it cannot accept this type of form, and they have had this problem with several physicians throughout the state. Mr. Kilborn's question is, "Can the state association do anything about physicians who refuse to use the standard Blue Shield card claim form?"

The administration of Blue Shield has suggested it might be necessary to discontinue making the check payable to both the physician and the patient if the doctor does not conform to using its standard card form. Dr. Steen said the information given on the standard insurance form is the information that the Blue Shield card requires and transfer of this information to the card should be considered a part of the Blue Shield's cost of doing business. (Discussed by Drs. Petrich, Bibler and Rifner.)

b. Dr. Steen also discussed the problem of accepting assignments on over-65 welfare patients. He reported that Mr. Kelly of the Welfare Department said that Blue Shield is willing to break this contract if this is the wish of the Council. Mr. Kelly asked for the help of the state association in this matter.

c. The chairman of the Council announced that Drs. Neumann and Edwards would attend the Blue Shield meeting on July 24, representing the liaison committee.

Dr. Kerr moved that Blue Shield not be called The Doctors' Plan, as many claims by laymen are turned down as not substantial due to diagnostic coverage, so called. (Motion was not seconded.)

The chairman of the Council suggested that the Blue Shield Board be invited to meet with the Council to indoctrinate fellow members who guide Blue Shield — to tighten ties with colleagues who are supposed to represent Indiana medicine, and stressed the need to get the Council and physicians on the Blue Shield Board working together.

DR. SHIELDS discussed the demands of carriers and hospitals relative to certification of Medicare patients and the refusal of the Blues to permit direct billing by hospital-based specialists. He stated that the AMA president-elect, Dr. Milford Rouse, is not going along with the long form and is admitting his patients under his customary past way, with the statement, "This man is being admitted for . . . ."

Dr. Shields said the question is, "Are we going to sign the long forms which are in the offing, or are we going to do what our president-elect of the AMA is doing?"

Dr. Shields suggested that the Indiana field secretaries should be better informed and for this reason they should be permitted to attend the AMA meetings.

2. *Legislative Matters.* DR. DWIGHT W. SCHUSTER, chairman of the Commission on Legislation, presented, for the information and consideration of the Council, some of the proposed legislation which will come before the next General Assembly. He briefed the Council on nine subjects of special interest to the medical profession on which bills are already in preparation.

Dr. Offutt said he had registered an official complaint on the proposed hearing aid bill on the basis that the State Board of Health would be charged with implementation of the law, and the state board does not operate in this field.

On motion of Drs. Popp and Corcoran, the Council went on record as "approving the work of the Commission on Legislation and giving them such authority as they deem appropriate to carry out their good work."

Matters Referred to Council by Executive Committee

DR. G. O. LARSON, Executive Committee member, in the absence of Dr. Ralph Everly, chairman, presented the following matters:

(1) Your Executive Committee recommends to the Council that the association legal counsel proceed to draw up appropriate amendments to the Constitution and Bylaws which will set forth conditions of membership. This is then to be referred back to the Executive Committee and to the Commission on Constitution and Bylaws for introduction to the House of Delegates at the October meeting.

This association is on record as declaring it unethical for physicians to dispose of their services in an unethical manner. The American Medical Association has taken like action at the June meeting. Our bylaws, we feel, are not sufficiently specific in this area, and we feel it should be spelled out in such a manner that any physician seeking membership in our organization will know just what he is subscribing to, in order to become a member. Also, legal counsel has advised that if we decide to take any steps in enforcing the ethics as we understand them, we might find it difficult inasmuch as they are not clearly set forth in our bylaws. Mr. Chairman, your Executive Committee recommends to the Council that this recommendation be approved by the Council.

(In view of the fact that this will be reviewed by the Commission on Constitution and Bylaws and presumably will be reported back to the Council, **on motion of Drs. Steen and Corcoran, this recommendation was approved by the Council.)**

(2) Your Executive Committee discussed for hours the contract which has been signed between Blue Cross and Blue Shield and the state of Indiana as it deals with acting as fiscal intermediary for the State Welfare Department. Your Executive Committee recommends to the Council that the Council notify the Blue Shield Board that it disapproves of this contract, as the contract is illegal in its content. The agreement presently reads in its last "Whereas" as follows:

"WHEREAS, the contractor has facilities and desires to furnish said hospital professional and medical services to said welfare recipients."

We recommend that this Council instruct the Blue Shield Board to insist on changing this to read:

"WHEREAS, the contractor has the facilities and desires to provide reimbursement for said hospital, professional and medical services, for said welfare recipients."

Legally the plan does not and cannot under Indiana law provide medical services, professional services or hospital services.

We also recommend the Council insist on changing the first paragraph of the agreement. Said paragraph presently reads as follows:

"NOW, THEREFORE, the parties agree as follows:

"1. The Contractor agrees to provide hospital, professional and medical services as specified in Parts A and B of Title XVIII of the Social Security Act to recipients of Public Assistance in the State of Indiana of the age of 65 years or older. These services will be provided under the general supervision of the Department of Welfare and the Contractor will furnish such services to the Department for those persons so designated."

We recommend the Council insist that the Blue Shield Board change this wording to read as follows:

"1. The Contractor agrees to provide reimbursement for the payment of professional medical services and hospital services as specified in Parts A and B of Title XVIII of the Social Security Act to recipients of Public Assistance in the State of Indiana of the age of 65 years or older, for those persons so designated as eligible by said department."

Mr. Chairman, this completes this recommendation and we seek concurrence of the Council in this recommendation.

In the opinion of the Executive Committee, the Council should take appropriate action to express to the Board of Blue Shield its strong disapproval of the manner in which this contract was drawn and the content of said agreement as approved by the Executive Committee of Blue Shield. The provisions of this agreement are in direct conflict with the policy of the medical profession of Indiana as expressed by the House of Delegates of this association.

Mr. Chairman, the Executive Committee would like the approval of the Council for this recommendation.

The Exccutive Committee further recommends that this Council remind the Blue Shield Board that the Indiana State Medical Association by resolution adopted by the House of Delegates, and by resolution adopted by the House of Delegates of the AMA, that assignments not be taken under the provisions of PL 89-97, rather they should bill direct and collect for their own services, and that Blue Shield not enter into any agreement that would be contrary to the stated position of the medical profession.

Mr. Chairman, we recommend approval of this statement.

(Discussed by Dr. Neumann.)

On motion of Dr. Steen, seconded by many, the Council voted to accept the report of the Executive Committee as a whole, and further that "should it not be possible to amend the contracts in the manner in which we wish, that they be requested to attempt in every manner to break the contract they have entered into."

(Discussed further by Drs. Owsley, Corcoran and Rifner.)

Dr. Petrich read a letter in which a member in his district suggested the following procedure for handling welfare cases and **moved that the Council accept this procedure as the policy of the state medical association until a previous motion which was approved by the Council is implemented into the state medical association:**

"The physician should be able to handle this without accepting assignments. I would suggest: Physicians continue to fill out the Department of Welfare form 174. When the account is paid to the physician he will inscribe a receipt for the account. This receipt will

be forwarded to the welfare department and they, in turn, will submit the receipt to the Medicare carrier for payment."

Dr. Petrich's motion was seconded by Dr. Kerr, put to vote, and carried.

DR. LARSON continued with the report from the Executive Committee:

(3) Your Executive Committee notes that Dr. Dunham has dismissed his suit against the Wabash Hospital. You will remember this Council authorized legal counsel to take appropriate steps to obtain a clear-cut decision on the right of Blue Cross to "provide professional services" under their contract; in other words to remove all professional services from the Blue Cross contract and place them in the Blue Shield certificate. When the Dunham case presented itself, it was thought this would be an appropriate vehicle to obtain this decision legally. Now that the case has been dismissed, and was in effect won by Dr. Dunham, it still leaves us without legal precedent and we could have a continuous series of suits in this area. The Council previously instructed legal counsel to attempt to effect a compromise or a transfer agreement without legal action, but, failing in this, to take the matter all the way to the Supreme Court, if necessary to obtain a favorable decision. Your Executive Committee recommends to the Council that they instruct legal counsel to proceed by taking the steps as originally authorized in order to resolve this matter.

Mr. Chairman, your Executive Committee recommends approval of this recommendation.

On motion of Drs. Steen and Petrich, the Council voted approval of the recommendation of the Executive Committee that legal counsel be instructed to proceed, on behalf of the state medical association, as originally authorized, to obtain a decision on the right of Blue Cross to provide professional services under their contract.

(4) Dr. Larson called attention to the increasingly large number of requests received in recent months for remission of state dues of physicians who had retired. Fifty-one members have been excused by the Council from payment of dues in 1966. According to the bylaws, financial hardship is the only basis upon which the Council should consider the remission of dues of any member.

On motion of Drs. Steen and Petrich, it was voted that in the future the Council will follow the Constitution and Bylaws explicitly in the matter of remission of state dues.

Economic and Organization Matters

1. **Request for remission of state dues of two members in the Eleventh District was denied on motion of Drs. Kerr and Petrich, as these members, it was determined, are not eligible under the bylaws of the association.**

2. *Nominations of two members for Editorial Board* for three-year term ending December 31, 1969, to succeed Drs. George M. Johnson, Richmond (surgery), and Irvin W. Wilkens, Indianapolis (internal medicine), whose terms expire December 31, 1966. **On motion of Drs. Tindall and Taylor, Dr. Johnson was nominated to succeed himself. On motion of Drs. Butler and Olvey, Dr. Wilkens was nominated to succeed himself.**

3. *Election of two members to Trust Committee of Indiana Medical Education Foundation, for the three-year term ending October 31, 1969.*

On motion of Drs. Kerr and Olvey, Dr. Donald E. Wood and Dr. Roy Geider were elected to succeed themselves as members of the Trust Committee of the Indiana Medical Education Foundation for the three-year term ending October 31, 1969. Membership of this committee for the ensuing three years is as follows:

	Term Expires
James W. Denny, Indianapolis	Oct. 31, 1967
Loren H. Martin, Indianapolis	Oct. 31, 1967
Jack H. Hall, Indianapolis	Oct. 31, 1968
Robert D. Pickett, Indianapolis	Oct. 31, 1968
Donald E. Wood, Indianapolis	Oct. 31, 1969
Roy Geider, Indianapolis	Oct. 31, 1969

4. *District nominations for Blue Shield Board of Directors for three-year terms ending March, 1970, were reported as follows:*

District 4 — Joe M. Black, Seymour, general practice, renominated.

District 7 — Glen V. Ryan, Indianapolis, general practice, renominated.

New Business

1. *Resolution Limiting Blue Shield Board Membership.* **On motion of Drs. Corcoran and Kerr, the Council approved the following resolution (as proposed by Dr. Corcoran) and its introduction to the House of Delegates:**

WHEREAS, the Indiana State Medical Association has for some time limited the tenure of office of members of the Council and of the commissions and committees to two successive terms, and

WHEREAS, within the membership of the association are many with diversified talents who should be encouraged to put them to use, and

WHEREAS, the many and varied problems facing us today may demand new and fresh approaches,

NOW THEREFORE BE IT RESOLVED, that the terms of the directors of Mutual Medical Insurance, otherwise known as Blue Shield, be limited to no more than three successive full terms under stipulations comparable to those set forth in Chapter VIII, Section 5, of the ISMA Bylaws, and

BE IT FURTHER RESOLVED, that suitable resolutions be prepared for enactment by the House of Delegates at its next meeting to effect these changes.

2. *Resolution Defining Ethics with Regard to Prescription of Medication.* **On motion of Drs. Corcoran and Kerr, the Council approved introduction of the following resolution to the House of Delegates:**

WHEREAS, some criticism has been directed toward the health professions because of alleged inter-relationships between physicians who prescribe medications or therapeutic devices and those who fill them, whereby financial benefits may accrue to the prescriber, and

WHEREAS, organized medicine has long advocated complete freedom of choice for our patients in seeking and obtaining all aspects of their health care, and

WHEREAS, we believe that most practitioners are presently acting fully in accord with this principle,

NOW THEREFORE BE IT RESOLVED, that the Indiana State Medical Association urges each of its members to review all present or projected methods of providing medications or devices with careful attention to any possible encroachment of the patient's right of complete free choice in selecting the source of prescribed agents, and

BE IT RESOLVED, that if such actual or potential abridgement of this freedom be discovered, it be promptly corrected, and

BE IT FURTHER RESOLVED, that each component medical society be asked to take appropriate measures to promote these objectives.

3. *Emergency Room Problems in Hospitals.* Dr. Hillis asked that this subject be discussed with at least two points in mind: (a) the legal responsibility of indigent and undesirable patients who present themselves at the emergency room, and (b) the action which is taken by many hospitals in forcing staff members to cover the emergency room. Dr. Hillis said he thought this Council should establish a policy about these two items.

Following discussion by many, **the chairman appointed a committee composed of Dr. Hillis, chairman, Drs. Wiseman, Olvey, Reid and Hoyt, to consider this matter, and to present to the Council at its next meeting a definitive program or policy which can be referred to the proper commission for further study.**

Reports of Guests

DR. GLENN W. IRWIN, JR., Dean, I.U. School of Medicine, spoke of the I.U. plan for statewide medical education and the great

deal of interest that this program has created, not only in the state but in the nation.

"We still feel that our plan is sound. Last month, for example, we conferred the M.D. degree on 172 new physicians. Only 75 of them have elected to stay in the state of Indiana for internships this year. To us, that is the crux of the problem. As we travel around the state, there is obviously very sincere and genuine interest in many communities and hospitals and on the part of physicians to really roll up their sleeves and to participate in educational activities for medical students, interns and residents.

"A great deal of time has been devoted to curriculum this year, and many of you are aware of the direction which we have recommended for curriculum. This year we are trying our best, before any major curriculum change occurs, to get selected students out over the state in certain clinical elective courses so they can see the good practice of medicine in a variety of areas of the state.

"We now have an associate dean, as many of you know, George Lukemeyer, who will be in charge of postgraduate and continuing medical education. He is in the process of developing a staff which will carry out in a new manner this form of education for our school.

"We, too, have been involved in Medicare and are trying to adapt these new regulations to our situation. We plan to submit a planning grant request under the Heart Disease-Cancer-Stroke bill. This grant request should go before the Council sometime in October, or perhaps in September. The advisory council required by this particular legislation is now being formed. Some of you have already received invitations to be members of this advisory group. This association is well represented as are our other organizations such as voluntary health agencies, State Board of Health, important citizens, laborers, communications, etc. We feel that we are quite likely to qualify for one of these regional programs, and we feel that it will dovetail very nicely with the plan for statewide medical education as we have conceived it. I hope a year from now we will be well down the road in really a new direction as far as our school of medicine is concerned. Thank you."

DR. A. C. OFFUTT, State Health Commissioner, reported on Medicare insofar as his department is concerned. "One hundred and twenty-nine hospitals (out of 133 eligible) are now certified by Social Security for participation. Some of those not certified, for several reasons, will come in within the next 30 days. Sixteen home health agencies have been certified. I have made an official request to Social Security, pointing out that one of the things that prevents certain additional agencies from certification for a home health service are the restrictive conditions for participation. For example, the nursing function must be provided directly, no contract basis can be used. This has effectively limited participation — Marion County is a notable example.

"As far as the independent laboratory certification is concerned, restrictive conditions bid fair to be extremely troublesome. No independent laboratories have been certified yet; a number of them have been recommended for certification; they haven't been certified because of delay in formulation of final regulations. We found that when we received the initial conditions for participation there were restrictive clauses which were unexpected and difficult of compliance. One of our real difficulties was the fact that only two laboratories may be supervised by a single individual and daily visits are required.

"In the state of Indiana, as you know, probably the success of our hospital laboratory program has been based on the fact that some pathologists supervise five or six hospital laboratories in addition to their own private laboratory. The pathologists that I've talked to advise me that daily visits are unnecessary. Our experience would indicate that this is so. I have made an official request to Social Security that this be changed. We have a communication from Social Security saying that we may approve these laboratories on an interim basis, inspect them sometime between July 1 and January 1, 1967. Then Social Security wrote to us and said that they had received numerous comments and suggestions which will be taken into account in the formulation of the final regulation. So actually these final regulations should be out on the 22nd of July. In the meantime, we've recommended the certification of 57 independent laboratories in Indiana. Now this leaves quite a few others that haven't been certified who perhaps can be: some of whom have not applied or have not indicated their interest in application."

Question: "Dr. Offutt, are radiology laboratories run by radiologists governed by this too?"

Dr. Offutt: "Yes. There are 40 certified. We didn't have any problem with these. Twelve for full clinical services; four for clinical and radiological and one for limited clinical service."

Dr. Offutt was asked the question, "How will it supply the groups which have a laboratory, like a clinic? I understand the individual can't choose his laboratory."

Dr. Offutt: "Where there's a group practice, this is one of the questions pending. The question is what does the law require as far as the qualifications of the individual. It requires (1) a pathologist, or (2) somebody who is certified by the American Board of Microbiology, and, I think, two others, clinical chemistry is one.

"We are going to try to get this home care agency philosophy changed by Washington. I have been advised that the only way to do it is by legislative pressure, and I think it is important that we do this."

There being no further business, the Council adjourned to meet again at 8:00 a.m., Monday, October 10, 1966, in the Terrace Room, French Lick-Sheraton Hotel, French Lick, Indiana (breakfast meeting).

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*Marks, V., and Dawson, A.: Brit. M. J. *1*:293, 1965.

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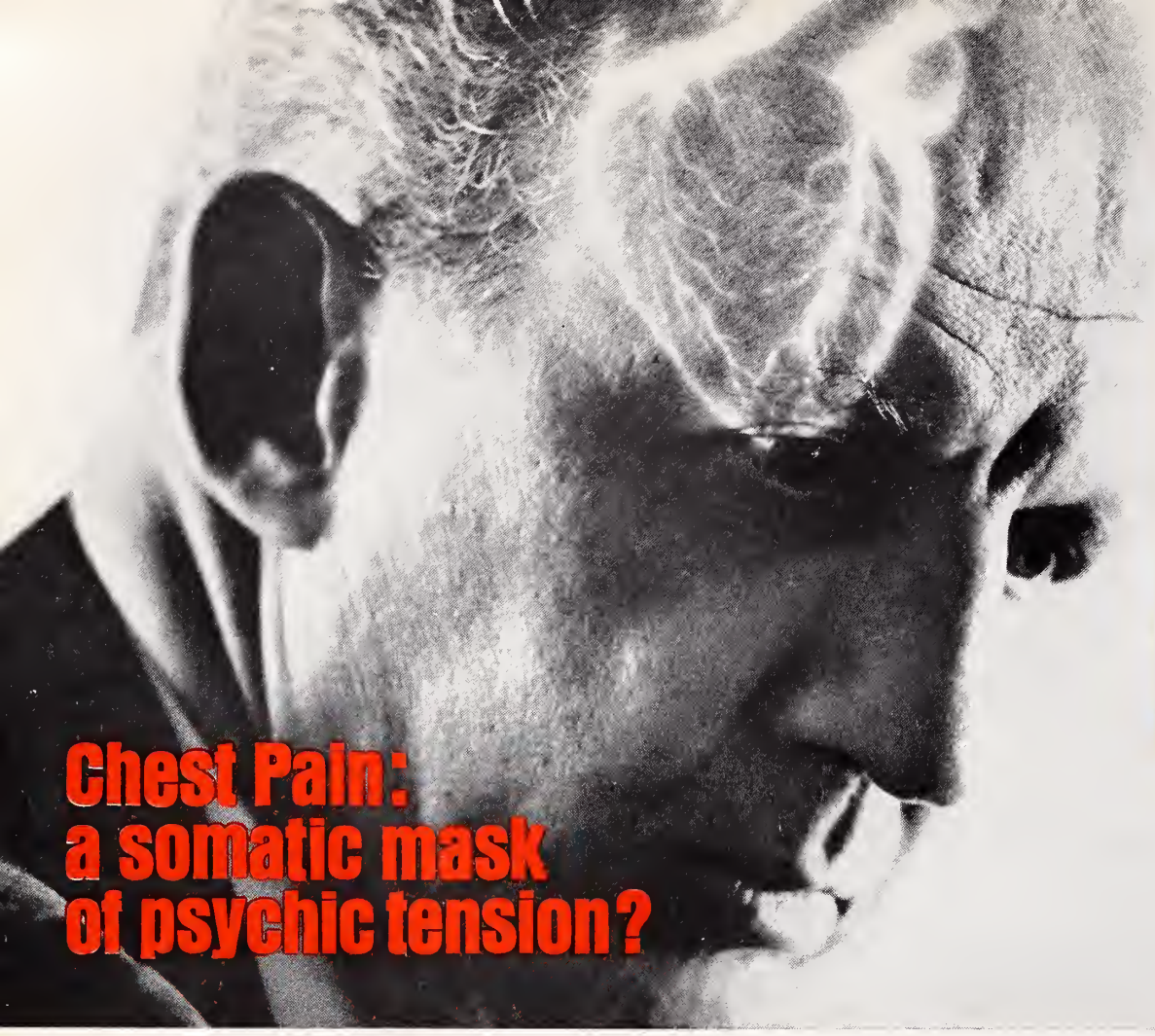

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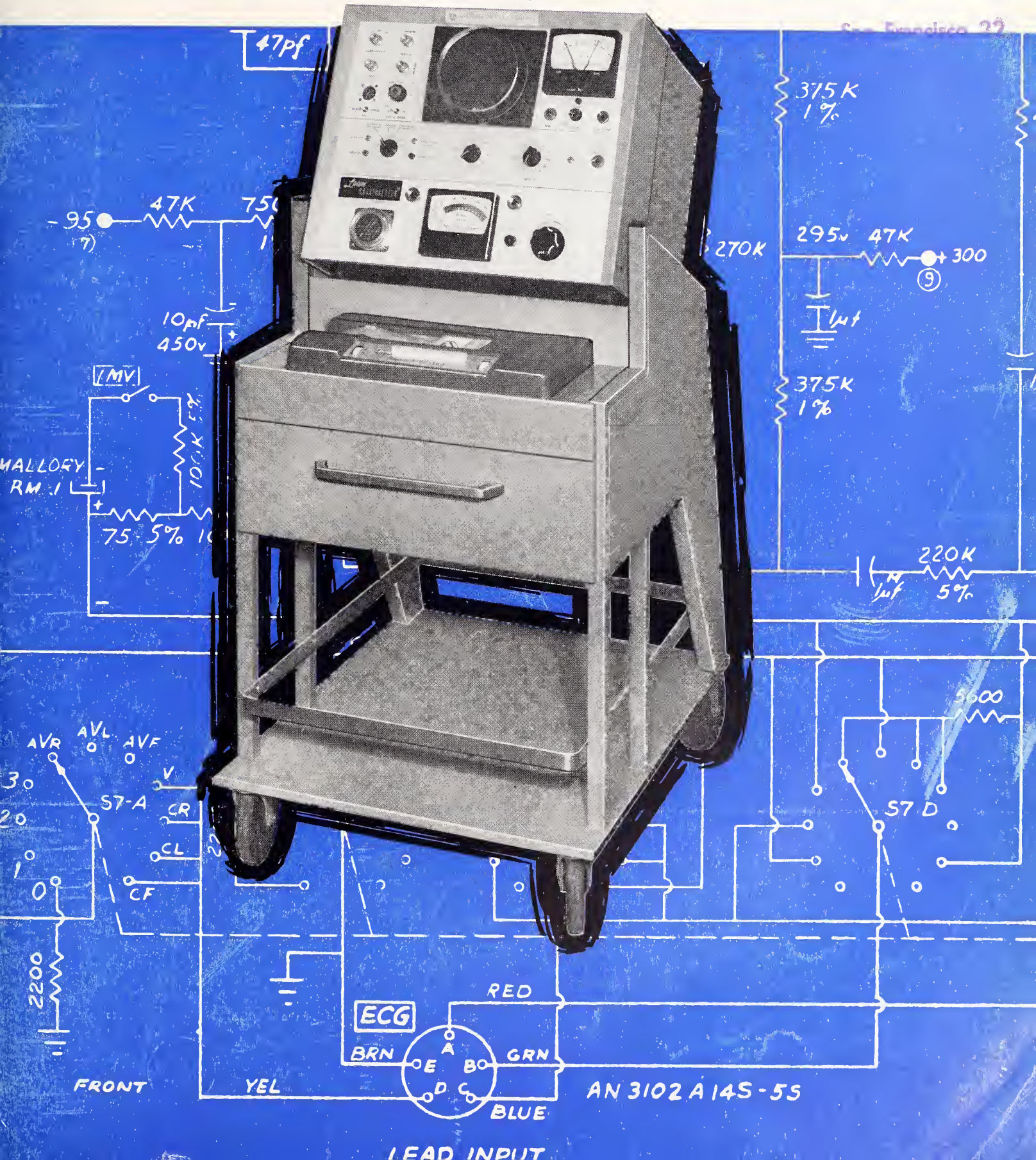

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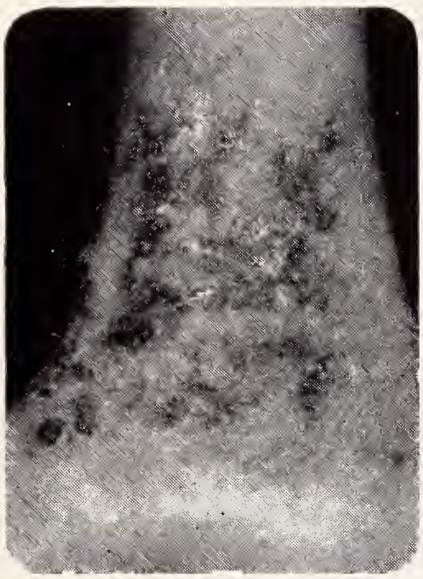
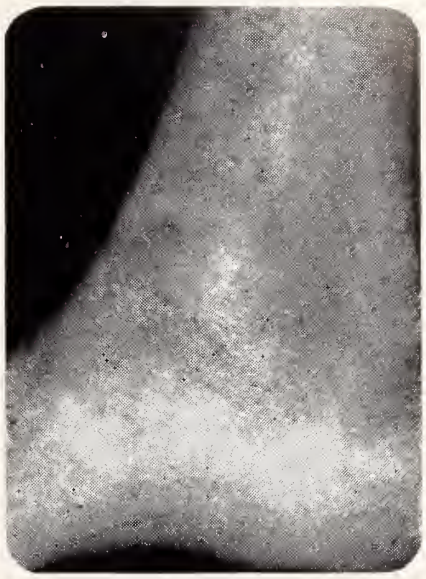
eczema: scourge of childhood



R. R., Age 11—Before treatment—atopic eczema of long standing



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Contraindications: Tuberculosis of the skin, herpes simplex, chicken pox and vaccinia.

Precautions and Side Effects: Do not use in the eyes or in the ear (if drum is perforated). A few individuals react unfavorably under certain conditions. If side effects are encountered, the drug should be discontinued and appropriate measures taken. Use on infected areas should be attended with caution and observation, bearing in mind the potential spreading of infection and the advisability of discontinuing therapy and/or initiating antibacterial measures. Generalized dermatological conditions may require systemic corticosteroid therapy. Steroid therapy, although responsible for remissions of dermatoses, especially of allergic origin cannot be expected to prevent recurrence. The use over extensive body areas, with or without occlusive nonpermeable dressings, may result in systemic absorption. Appropriate precautions should be taken. When occlusive nonpermeable dressings are used, miliaria, folliculitis and pyodermas will sometimes develop. Localized atrophy and striae have been reported with the use of steroids by the occlusive technique. When occlusive nonpermeable dressings are used, the physician should be aware of the hazards of suffocation and flammability. The safety of use on pregnant patients has not been firmly established. Thus, do not use in large amounts or for long periods of time on pregnant patients.

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vignettes of angina pectoris—
no. 1 in a series:

angina and the surgeon

John Hunter—
British surgeon (1728-1793)

angina of anger

"My life is in the hands of any rascal who chooses to annoy and tease me."[1] So said the great British surgeon and anatomist, John Hunter, realizing that he could not control the anger which precipitated frequent and severe attacks of angina pectoris. According to Mettler: "His statement was no exaggeration. On October 16, 1793, he attended a meeting of the St. George's hospital staff, and, while defending the interests of several students, he was contradicted and thoroughly antagonized. The pains of angina commenced, he started toward another room, gained it, and fell dying into the arms of a physician."[2]

Why Edward Jenner withheld his paper on angina In 1777, at an earlier stage of the condition, Hunter's angina alarmed a favorite pupil, Edward Jenner, who wrote to Dr. Heberden that he feared his teacher was "affected with symptoms of the Angina Pectoris."[3] So concerned was Jenner about his former teacher's emotion-related condition that he deliberately cancelled publication of a paper on angina pectoris, fearing that Hunter would read it, and have "his fears excited by its truly formidable nature."[4]

Severity of angina described Hunter's brother-in-law, Dr. Everard Home, who witnessed his death and performed an autopsy, gave this account of the later stages of the condition:

"...the pain became excruciating at the apex of the heart; the throat was so sore as not to allow of an attempt to swallow anything and the left arm could not bear to be touched....

"The affections above described were, in the beginning, readily brought on by exercise... but they at last seized him when lying in bed, and in his sleep...."[5]

18th century ancestor of the modern coronary candidate Surgeon, anatomist, pathologist, physiologist, geologist, and teacher, Hunter had a passion for research which led him to disregard his practice, his health and even the

law. When the Irish giant O'Brien learned that Hunter desired his skeleton for a museum, he willed that his body be sunk at sea in a lead coffin. But Hunter was not to be denied. According to Major, he "... bribed the watchers and finally obtained the body at a cost of 500 pounds although he had to borrow the money to pay the men."[3]

In 1767, he experimentally inoculated himself with gonorrhea and syphilis, treated himself with mercury for three years, and was apparently cured.[5] Hunter had feelings of inadequacy about his education and speaking ability, but this did not prevent him from being hard driving and abrupt with his colleagues. His competitiveness with his physician older brother was also well known, and ended in complete estrangement between the two men.[2,3] Today, the personality traits seen in John Hunter are recognized to be important predisposing factors in the development of coronary artery disease—often manifested as angina pectoris. According to Friedman and Rosenman,[6] in a group of men whose behavior was characterized by intense ambition and competitive drive, a greater than average incidence of angina pectoris was among those abnormal conditions noted.

References: 1. Paget, S., cited by Mettler, C. A.: History of Medicine, Philadelphia, The Blakiston Company, 1947, p. 85. 2. Mettler, C. A.: *Op. cit.*, pp. 84-85. 3. Major, R. H.: A History of Medicine, Springfield, Ill., Charles C Thomas, 1954, vol. 2, pp. 601-607. 4. Baron, J., cited by Major, R. H.: *Op. cit.*, p. 607. 5. Major, R. H.: Classic Descriptions of Disease, ed. 3, Springfield, Ill., Charles C Thomas, 1955, p. 423. 6. Friedman, M., and Rosenman, R. H.: J.A.M.A. *169*:1286, 1959.

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Peritrate (pentaerythritol tetranitrate) is a nitric acid ester of a tetrahydric alcohol (pentaerythritol).

Actions: The exact cause of angina pectoris (that is, the pain associated with coronary artery disease) remains obscure, despite the numerous and often conflicting hypotheses concerning its pathophysiology. Therapy at the present time, therefore, remains essentially empiric. Customarily, clinical improvement has been measured by: reduction in (1) number, intensity and duration of angina pectoris attacks and (2) necessity for glyceryl trinitrate intake for prevention or relief of anginal attacks.

Peritrate SA Sustained Action (pentaerythritol tetranitrate) 80 mg. has been reported in clinical usage to reduce in number and severity the incidence of angina pectoris attacks, with concomitant reduction in glyceryl trinitrate intake.

In the evaluation of Peritrate (pentaerythritol tetranitrate) and Peritrate SA Sustained Action (pentaerythritol tetranitrate) 80 mg. in angina pectoris, clinical improvement has been customarily measured subjectively by reduction in number and severity of attacks and necessity for glyceryl trinitrate intake for prevention or abortion of anginal attacks. Individual patterns of angina pectoris differ widely as does the symptomatic response to anti-anginal agents such as pentaerythritol tetranitrate. The published literature contains both favorable and unfavorable clinical reports. In conjunction with total management of the patient with angina pectoris, Peritrate (pentaerythritol tetranitrate) and Peritrate SA Sustained Action (pentaerythritol tetranitrate) 80 mg. have been accepted as safe for prolonged administration and widely regarded as useful.

Animal pharmacology: In a series of carefully designed studies in pigs, Peritrate (pentaerythritol tetranitrate) was administered for 48 hours before an artificially induced occlusion of a major artery and for seven days thereafter. The pigs were sacrificed at various intervals for periods up to six weeks. The result showed a significantly larger number of survivors in the drug-treated group. Damage to myocardial tissue in the drug-treated survivors was less extensive than in the untreated group. Pigs rather than dogs were used because their coronary artery distribution more closely resembles that of human beings. Studies in dogs subject to oligemic shock through progressive bleeding have demonstrated that Peritrate (pentaerythritol tetranitrate) is vasoactive at the post-arteriolar level, producing increased blood flow and better tissue perfusion. These animal experiments cannot be translated to human behavior

Indications: Peritrate SA Sustained Action (pentaerythritol tetranitrate) 80 mg. is indicated for the relief of angina pectoris (pain associated with coronary artery disease). It is not intended to abort the acute anginal episode but is widely regarded as useful in the prophylactic treatment of angina pectoris.

Contraindications: Peritrate SA Sustained Action (pentaerythritol tetranitrate) 80 mg. is contraindicated in patients who have a history of sensitivity to the drug.

Warning: Data supporting the use of Peritrate (pentaerythritol tetranitrate) during the early days of the acute phase of myocardial infarction (the period during which clinical and laboratory findings are unstable) are insufficient to establish safety.

Precautions: Should be used with caution in patients who have glaucoma.

Adverse reactions: Side effects reported to date have been predominantly related to headache (which may require discontinuation of medication) and gastrointestinal distress which are usually transient with continuation of medication.

Dosage: Peritrate SA Sustained Action (pentaerythritol tetranitrate) 80 mg., 1 tablet immediately on arising and 1 tablet 12 hours later (on an empty stomach).

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4.	Harald W. Richmond, Columbus	David L. Adler, Calumbus	Columbus, 1967
5.	Jahn Ellett, Jr., Caatesville	Richard Veach, Bainbridge	Greencastle, May 17, 1967
6.	J. J. Farrell, Jr., Greenfield	Stephen D. Smith, Knightstown	
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9.	Harry T. Stout, Frankfort	Earl K. Williams, Frankfort	May 18, 1967
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12.	Warren L. Niccum, Columbia City	Kenneth F. Isenogle, Fart Wayne	Fort Wayne, May 17, 1967
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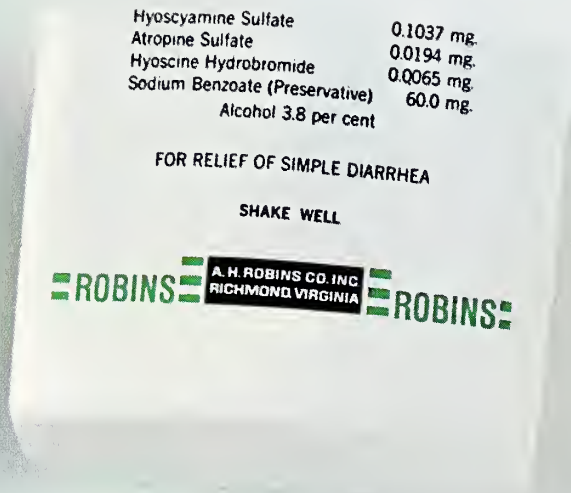

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References: 1. Kramer, P., and Ingelfinger, F.J.: Med. Clin. N. Amer., *32*:1227, 1948. 2. Hock, C.W.: Clin. Med., *8*:1932, 1961. 3. Winfield, I.W.: Am. J. Gastroent., *31*:438, 1959.

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chlorthalidone 50 mg. reserpine 0.25 mg.

1 tablet daily brings pressure down

Advantage: Both components of Regroton are long-acting.
Average dosage: One tablet daily with breakfast.
Contraindications: History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases.
Warning: Discontinue 2 weeks before general anesthesia, 1 week before electroshock therapy, and if depression or peptic ulcer occurs. With administration of enteric-coated potassium supplements, the possibility of small bowel lesions should be kept in mind.
Precautions: Reduce dosage of concomitant antihypertensive agents by one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take particular care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use with caution in patients with ulcerative colitis, gallstones, or bronchial asthma.
Side effects: Nausea, vomiting, diarrhea, muscle cramps, headaches and dizziness. Potential side effects include angina pectoris, anxiety, depression, drowsiness, hyperglycemia, hyperuricemia, lassitude, leukopenia, nasal stuffiness, nightmare, purpura, urticaria, and weakness.
For full details, see the complete prescribing information.
Availability: Bottles of 100 and 1000 tablets.

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Norinyl® tablets

(norethindrone 2 mg. c̄ mestranol 0.1 mg.)

for multiple contraceptive action that has produced a record of unexcelled effectiveness

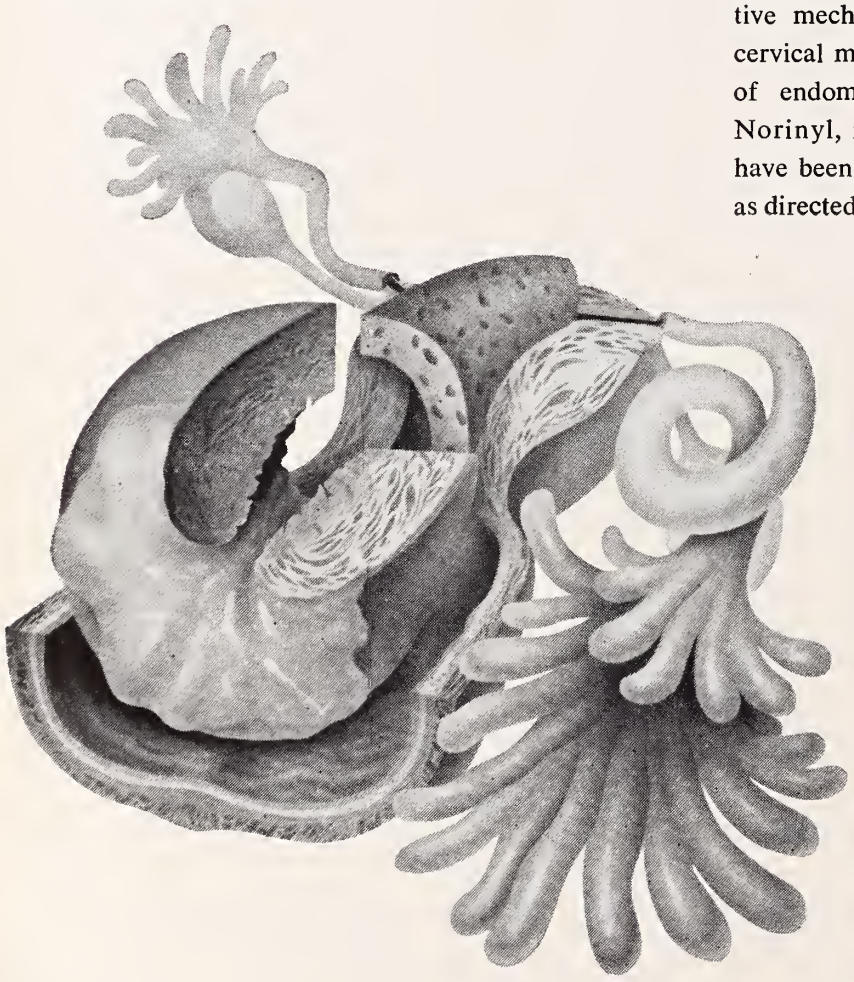
inhibition of ovulation by means of 2 time-proved hormonal agents

production of a cervical mucus hostile to sperm motility and vitality

creation of an endometrium unreceptive to egg implantation

no unplanned pregnancies

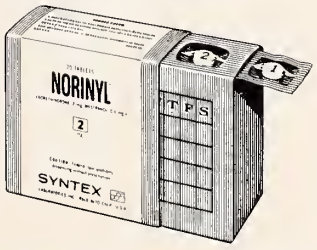
Norinyl provides multiple action for maximum assurance of success. It does not depend on ovulation inhibition alone for contraceptive effectiveness. The mechanism of action of combined hormonal therapy results in ovulation inhibition reinforced by other protective mechanisms, including a hostile cervical mucus[1-13] and an acceleration of endometrial changes.[1-3,7-16] With Norinyl, no unplanned pregnancies have been reported to date when used as directed.



plus important supportive benefits that help her through those critical early months of oral contraception

low incidence of side effects
Low incidence of BTB and spotting, nausea and amenorrhea tends to minimize side effect problems and increases patient cooperation.

no confusion about dosage
An unbreakable "confusionproof" package makes it easy to adhere to prescribed dosage schedule: individually sealed tablets numbered from 1 through 20 *plus* monthly calendar record enables patient to double-check dosage intake by day and corresponding tablet number.



Contraindications: Thrombophlebitis or pulmonary embolism (current or past). Existing evidence does not support a causal relationship between use of Norinyl and development of thromboembolism. While a study which was conducted does not resolve definitively the possible etiologic relationship between progestational agents and intravascular clotting, it tends to confirm the findings of the Ad Hoc Advisory Committee appointed by the Food and Drug Administration to review this possibility. Cardiac, renal or hepatic dysfunction. Carcinoma of the breast or genital tract. Patients with a history of psychic depression should be carefully studied and the drug discontinued if depression recurs to marked degree. Patients with a history of cerebral vascular accident.
Warning: Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn.
Precautions: By May 1963, experience with norethindrone 2 mg.—mestranol 0.1 mg. had extended over 24 months. Through miscalculation, omission or error in taking the recommended dosage of Norinyl, pregnancy may result. If regular menses fail to appear and treatment schedule has not been adhered to, or if patient misses two menstrual periods, possibility of pregnancy should be resolved before resuming Norinyl. If pregnancy is established, Norinyl should be discontinued during period of gestation since virilization of the female fetus has been reported with oral use of progestational agents or estrogen. When lactation is desired, withhold Norinyl until nursing needs are established. Existing uterine fibroids may increase in size. In metabolic or endocrine disorders, careful clinical preevaluation is indicated. A few patients without evidence of hyperthyroidism had elevated serum protein-bound iodine levels, which in the light of present knowledge, does not necessarily imply hyperthyroidism. Protein-bound iodine increased following estrogen administration. Bromsulphalein retention has occurred in up to 25% of patients without evidence of hepatic dysfunction. Studies from 24-hour urine collections have shown an increase in aldosterone and 17-ketosteroids and decrease in 17-hydroxycorticoid levels. Thus, Norinyl should be discontinued prior to and during thyroid, liver or adrenal function tests. Because progestational agents may cause fluid retention, conditions such as epilepsy, migraine and asthma require careful observation. Thus far no deleterious effect on pituitary, ovarian or adrenal function has been noted; however, long-range possible effect on these and other organs must await more prolonged observation. Norinyl should be used with caution in patients with bone, renal or any disease involving calcium or phosphorus metabolism.
Side Effects: Intermenstrual bleeding; amenorrhea; symptoms resembling early pregnancy, such as nausea, breast engorgement or enlargement, chloasma and minor degree of fluid retention (if these should occur and patient has not strictly adhered to medication plan, she should be tested for pregnancy); weight gain; subjective complaints such as headache, dizziness, nervousness, irritability; in a few patients libido was increased. In a total of 3,090 patients, 2.2% discontinued medication because of nausea.
NOTE: See sections on contraindications and precautions for possible side effects on other organ systems.
Dosage and Administration: One Norinyl tablet orally for 20 days, commencing on day 5 through and including day 24 of the menstrual cycle. (Day 1 is the first day of menstrual bleeding.)
Availability: Dispensers of 20 and 60 tablets; bottles of 100.

References: **1.** Council on Drugs. JAMA 187:664 (Feb. 29) 1964. **2.** Bryans, F. E.: Canad Med Ass J 92:287 (Feb. 6) 1965. **3.** Goldzieher, J. W.: Med Clin N Amer 48:529 (Mar.) 1964. **4.** Cohen, M. R.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965. **5.** Hammond, D. O.: Ibid. **6.** Rice-Wray, E., Goldzieher, J. W., and Aranda-Rosell, A.: Fertil Steril 14:402 (Jul.-Aug.) 1963. **7.** Goldzieher, J. W., Moses, L. E., and Ellis, L. T.: JAMA 180:359 (May 5) 1962. **8.** Kempers, R. D.: GP 29:88 (Jan.) 1964. **9.** Tyler, E. T.: JAMA 187:562 (Feb. 22) 1964. **10.** Rudel, H. W., Martinez-Manautou, J., and Maqueo-Topete, M.: Fertil Steril 16:158 (Mar.-Apr.) 1965. **11.** Flowers, C. E., Jr.: N Carolina Med J 25:139 (Apr.) 1964. **12.** Goldzieher, J. W.: Appl Ther 6:503 (June) 1964. **13.** The Control of Fertility. Report adopted by the Committee on Human Reproduction of the American Medical Association. JAMA 194:462 (Oct. 25) 1965. **14.** Flowers, C. E., Jr.: JAMA 188:1115 (June 29) 1964. **15.** Merritt, R. I.: Appl Ther 6:427 (May) 1964. **16.** Newland, D. O.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965.

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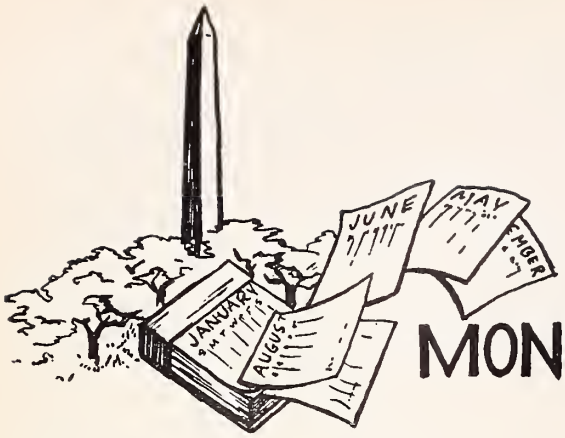


This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

MONTH IN WASHINGTON

WASHINGTON, D.C.—A new minimum wage law is expected to cause hospital and nursing home costs to rise.

IT BRINGS about 1.5 million workers in hospitals and nursing homes under the federal minimum wage program for the first time. The minimum wage for them is set at $1.00 an hour for next year, $1.15 an hour in 1968, $1.30 an hour in 1969, $1.45 an hour in 1970 and $1.60 an hour thereafter.

THE NEW LAW also increases the minimum wage for about 30 million workers presently covered to $1.40 an hour on Feb. 1, 1967, and to $1.60 an hour on Feb. 1, 1968.

ON A RELATED FRONT, Senate Democratic Leader Mike Mansfield (Mont.) said he believed the Health, Education and Welfare Department was going too fast in enforcing racial desegregation of southern hospitals and schools. He told newsmen he supported the Senate's denial of $500,000 sought by HEW to pay civil rights investigators. He said the Senate wants to see desegregation handled carefully rather than impulsively.

HOSPITAL and school authorities "will be on trial," Mansfield said, and if they abuse the suggested latitude, Congress can move quickly to correct the situation.

"WE HAVE to take things slowly . . . ." he said. "This is an area of great delicacy. The thing to do is to do it right and not precipitously."

THE SENATE approved legislation that would give nursing homes more liberal payment for medicare patients. The bill amends the definition of reasonable costs to include return on the fair market value of the facilities. The existing federal reimbursement formula is two percent above operating costs. Nursing home operators contend this is too low.

HEW UNDERSECRETARY Wilbur Cohen said the government will watch carefully to determine whether patients are admitted unnecessarily to hospitals next year in order to qualify them for medicare's nursing home benefits. The law requires that nursing home benefits be made available only to medicare beneficiaries who have had a hospital stay of three days or more and only when the nursing home care is considered an extension of the hospital treatment. However, several bills have been introduced in Congress to eliminate the hospital stay requirement.

Continued

"'Tranquilizer' is not a good word"[1]

"THIS classification is psychologically too seductive, pharmacologically too unspecific, and in terms of results not infrequently untrue."[2]

What is a tranquilizer? According to the 24th Edition of Dorland's Medical Dictionary[3] a tranquilizer is "an agent which acts on the emotional state, quieting or calming the patient without affecting clarity of consciousness."

Defining a drug by its effects, however, can be misleading. The same effects by which the dictionary defines a tranquilizer have sometimes been seen after administration of a sedative — or, for that matter, a placebo.

Ambiguous though the term may be, it appears to be here to stay. The 1966 edition of the Physicians' Desk Reference[4] lists 42 tranquilizers indicated for treatment of anxiety and apprehensive states.

'Tranquilizers' have differences in action, differences in effect

Although all tranquilizers are intended to calm anxious patients there are differences in their actions — and in their effects. They have been divided into three categories — the rauwolfia group, the 'minor' tranquilizers, and the phenothiazines.[5]

Although the tranquilizing effect of rauwolfia has been known for centuries, its use as an antipsychotic agent in current practice has diminished.[5]

A 'minor' tranquilizer is often prescribed to achieve more than one effect. Thus, besides being tranquilizers some of these compounds may be muscle relaxants, antihistaminics with some calming action, anticholinergic sedatives, or antispasmodics.[5]

The phenothiazines are considered 'major' tranquilizers because they alter psychotic behavior.[1] This classification may have done them more harm than good because it implies that the phenothiazines should be reserved for the more severely disturbed. This is not necessarily true.

The phenothiazines — and the problem of sedation

One of the problems of prescribing phenothiazines for ambulatory patients has been the fear that excessive sedation will impair the patient's ability to function. This, however, is less of a problem with some of the phenothiazines.

"Clinically they may be differentiated primarily in terms of their potency and the extent of their sedative effect, which appear to be inversely proportional. That is, the least potent, the one which is used in highest dosage, chlorpromazine, is the most sedative, while the reverse holds true for fluphenazine."[6]

In a recent report on various studies conducted over several years evaluating 360 patients treated for anxiety and stress with seven phenothiazines, this inverse relationship of potency to sedation was confirmed.[7] Also under consideration was the degree to which the particular phenothiazines neutralized anxiety (the angolytic index). Interestingly enough there was, again, an inverse relationship. The most sedative of the phenothiazines appeared to be the least active in neutralizing anxiety. Fluphenazine, one of the least sedative, on the other hand, was found to be most effective in relieving anxiety.[7]

RELATIVE SEDATIVE AND ANGOLYTIC INDICES OF PRINCIPAL PHENOTHIAZINES*

DRUG	SEDATIVE INDEX	ANGOLYTIC INDEX	BASED ON STANDARD DOSE OF
Chlorpromazine	100	15	25 mgs.
Triflupromazine	100	15	25 mgs.
Thioridazine	90	17	25 mgs.
Perphenazine	15	25	4 mgs.
Carphenazine	25	25	25 mgs.
Trifluoperazine	3.3	95	2.0 mgs.
Fluphenazine	3.5	100	2.5 mgs.

*adapted from Sainz[7]

Prolixin is therapeutically effective without excessive sedation

When used as a 'tranquilizer' in general medical practice, in many patients Prolixin (Squibb Fluphenazine Hydrochloride) suppresses anxiety, but not normal activity. These two features are of particular importance to patients who must be able to live and work without their normal daily activities being restricted.

Because of its longer duration of action, Prolixin, in doses of as little as one to three milligrams in adults, generally taken once a day, is effective in maintaining many patients free of their symptoms of anxiety and tension.

Contraindications: Do not use with high doses of hypnotics or in patients with subcortical brain damage. Use with caution in patients with a history of convulsive disorders. Severe reactions may occur in patients with idiosyncrasy to other centrally-acting drugs, and severe hypotension may occur in patients with special medical disorders, e.g. mitral insufficiency and pheochromocytoma.

Precautions: Effects of atropine, anesthetics and C.N.S. depressants may be potentiated. Hypotension may occur in patients undergoing surgery. Do not use epinephrine for treatment of the hypotensive reactions which may appear in patients on phenothiazine therapy.

Side Effects: Extrapyramidal reactions, allergic skin reactions, the possibility of anaphylaxis, drowsiness, visual blurring, dizziness, insomnia, nausea, anorexia, salivation, edema, perspiration, dry mouth, abnormal lactation, polyuria, hypotension, and jaundice and biliary stasis may occur. Routine blood counts are recommended to determine possible blood dyscrasias; if symptoms of upper respiratory infection occur, discontinue drug and institute appropriate therapy.

Available: 1 mg. tablets. Bottles of 50 and 500.

For full prescribing information, see package insert

References: 1. Simpson, G.M.: Postgrad. Med. *39*:557, 1966. 2. Freyhan, F.A.: Am. J. Psychiat. *115*:577, 1959. 3. Dorland's Illustrated Medical Dictionary, ed. 24, Philadelphia, W. B. Saunders Co., 1965, p. 1603. 4. Physicians' Desk Reference, 1966, Oradell, N.J., 1965, p. 310. 5. Cohen, S.: Northwest Med.: *65*:197, 1966. 6. Detre, T., and Jarecki, H.: Connecticut Med. *25*:553, 1961. 7. Sainz, A.: Psychosomatics *5*:167, 1964.

PROLIXIN®

SQUIBB FLUPHENAZINE HYDROCHLORIDE

SQUIBB 'The Priceless Ingredient' of every product is the honor and integrity of its maker

Continued

AMA SUPPORTS AIR POLLUTION EXTENSION PROGRAM

THE American Medical Association supported a bill that would extend the air pollution program and authorize increased appropriations for it.

IN A LETTER to a Senate subcommittee, Dr. F. J. L. Blasingame, executive vice-president of the AMA, noted that the association's House of Delegates in June, 1965, had adopted a statement recognizing the health hazards resulting from air pollution and recommending that feasible reduction of all forms of air pollution should be sought by all responsible parties. The pending bill (S. 3112) "can further this end," he said.

"WE BELIEVE the effect of this amendment will be beneficial," he said. "The grant mechanism should bolster local and regional operations, encouraging a greater degree of local initiative, particularly in interstate and intermunicipal areas. In addition, the bill would eliminate a serious inequity in the present law. Certain metropolitan regions are penalized in that they cannot obtain assistance for maintaining their currently large and expensive programs, while a metropolitan region without a program could receive up to two-thirds of the cost of creating a new program. Under the proposed legislation this inequity would be eliminated."

NEW APPROACH TO DRUG ADDICTION

THE SENATE cleared the path for a new approach to narcotics addiction which would substitute hospital treatment for long-term prison sentences.

THE SENATE APPROVED the legislation by voice vote without dissent and sent it to a Senate-House conference committee for adjustment of differences with a House version.

THE KEY to the bill is civil commitment for the addict involved in a non-violent crime. It would provide voluntary pre-trial commitment in lieu of prosecution and compulsory post-conviction commitment in lieu of punishment. In addition, the bill would provide voluntary and compulsory commitment of certain addicts not charged with any crime. The addicts would be committed to the surgeon general for confinement and treatment in a hospital or institution. Treatment would continue within the community after the addict is discharged.

THE legislation also would establish federal post-hospitalization treatment centers and also give courts more flexibility in dealing with youthful drug offenders.

SEN. JOHN L. McCLELLAN, D-Ark., who brought the bill to the Senate floor, said it "affords an opportunity for narcotics addicts who wish to extricate themselves from a hopeless life of addiction and crime to have themselves committed for treatment."

"IT ALSO affords a civil, non-penal procedure for the compulsory

Continued

GENITOURINARY TRACT SPASM

Spastic conditions of the genitourinary tract as a result of inflammation or calculi are often difficult to treat due to the combination of voluntary and involuntary neural control of the system. Urine enters the bladder in periodic spurts brought about by successive peristaltic waves that begin in the smooth muscle of the renal pelvis and pass downward. The normal anatomical constrictions of the ureters are of clinical importance because they frequently inhibit the passage of small calculi.

Abnormal distention of the bladder as a result of an obstructed outlet due to stricture of the urethra or an adenomatous prostate often requires consideration of the smooth muscle involved. Because prostatic tubules invade the internal smooth muscle layer of the urethra, unusual enlargement of the prostate impedes the sphincter-like action of this muscle. Micturition, with inflammation of the bladder and attending atonicity, is more frequent and in cases of long duration (e.g. tuberculosis) contracture of the bladder approaches a permanent state. The clinical importance of the smooth musculature in the urinary tract cannot be overemphasized.

Artist's rendering of the urinary bladder illustrating the trigone, circular, and longitudinal layers of smooth muscle. Note the spray of fibers which passes from the trigone to the wall of the urethra.

© 1966 Philips Roxane, Inc

Philips Roxane Laboratories
Medical Illustration Series
Number Five — SPACOLIN
Additional copies available on request

The ureters are composed of three layers of smooth muscle, an inner longitudinal layer, a middle circular layer, and an outer longitudinal layer which course the entire length from the renal pelvis to the wall of the bladder where the ureters open as slit-like apertures for the most part retaining their own musculature. They are fairly uniform in size except for three slightly constricted portions, one at the ureteropelvic junction, the second at the pelvic brim, and the third at the extreme lower end of the ureter as it passes through the bladder wall.

The smooth musculature of the bladder is constituted in three general layers with poorly defined boundaries. The outer layer is composed mainly of longitudinal fibers which extend to the neck of the bladder where certain bundles unite to form a loop around the anterior surface of the vesical orifice. Within this loop, the circular layer forms a wedge below the outlet and flows down the urethra in an oblique direction surrounding the canal as a thin layer which, when stimulated, provides an upward pull on the urethral canal. The upward pull of this loop combined with the downward pull of the longitudinal layer gives a sphincter-like action to the musculature at the bladder neck although no true sphincter is present. The musculature of the trigone arises from the longitudinal muscle fibers of each ureter and spreads over the muscles of the bladder wall.

The male urethra is for the most part mucous membrane which contains loosely arranged longitudinal and circular smooth muscle layers. In the prostatic part at the neck of the bladder, the circular layer is highly developed and acts in harmony with the descending array of circular fibers of the bladder contributing to the sphincter-like control of the neck.

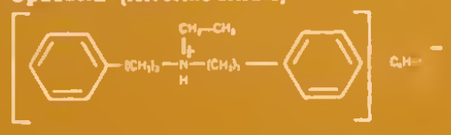
Spacolin (Alverine citrate) is a musculotropic antispasmodic which acts directly on the smooth muscle of the genitourinary tract with rapid onset and long duration. Because the parasympathetic nervous system is avoided, anticholinergic side effects do not occur. Moreover, Spacolin, (Alverine citrate) is ideally suited for relief of smooth muscle spasm in the presence of prostatic hypertrophy.

smooth muscle spasm

GENITOURINARY TRACT SPASM

PHARMACODYNAMICS OF SPACOLIN®
(Alverine citrate)

Spacolin (Alverine citrate)



- A potent musculotropic counter-spasmodic.
- Little or no effect on normal muscle tonicity and motility.
- Spasmolytic effect is 2½ to 3 times stronger than papaverine.
- Unrelated to atropine or atropine-like drugs.
- Therefore no atropine-like side effects such as dry mouth, blurred vision, constipation and urinary retention.
- Not contraindicated in glaucoma or prostatic hypertrophy.

FAST RELIEF OF SMOOTH MUSCLE SPASM

SPACOLIN®
(Alverine citrate)

Each tablet contains: Alverine citrate.....120 mg.

INDICATIONS: Smooth muscle spasmolytic for use in spastic colon, spastic conditions of the gastrointestinal tract, biliary dyskinesia, cholecystitis, spasm associated with peptic ulcer,* achalasia, pylorospasm, spasm attendant to diarrhea, spastic conditions of the genitourinary tract attributable to inflammation and calculi, certain primary dysmenorrheas and as an aid in cystoscopic, esophagoscopic and gastroscopic examinations.

PRECAUTION: Caution is recommended when using in hypotensive patients.

SIDE EFFECTS: In common with other smooth muscle depressants, Spacolin temporarily lowers blood pressure.

DOSAGE: One tablet after meals 1 to 3 times daily at discretion of physician. When treating spasm associated with peptic ulcer, achalasia or pylorospasm, administer tablets ½ hour before meals. In dysmenorrhea, one tablet 3 times daily starting at onset of discomfort.

SUPPLIED: Bottles of 100 and 500–120 mg. tablets.

*Antacid and dietary measures are of primary importance in ulcer treatment and should not be neglected.

PHILIPS ROXANE LABORATORIES
Division of Philips Roxane, Inc. Columbus, Ohio

Syncrome, Duphaston, Measles Vaccine, Acusol and Acutus are other significant products for your consideration.

"First with the Retro-Steroids"

PER℞SPECTIVE

The modern symbol for prescriptions can be traced to the ancient Egyptian sun god, Horus, whose eye was believed to possess great healing power. The Rx is all the more meaningful when viewed in the light of history.

The name White-Haines is also more meaningful when viewed with historical perspective. For 64 years we have served the ophthalmic profession with unparalleled laboratory facilities, superior craftsmanship, the finest optical supplies, and a dedication to customer satisfaction.

THE WHITE-HAINES OPTICAL COMPANY

HEADQUARTERS: COLUMBUS, OHIO

Serving Ohio • Michigan • Pennsylvania • West Virginia • Kentucky • Indiana • Illinois • Maryland

commitment of addicts not charged with a crime so they may be cured and rehabilitated before they are forced by their addiction into a repetitious pattern of addiction and crime," he added.

SEN. THOMAS J. DODD, D-Conn., who for years has studied the problem of narcotics, said the bill "will lead to a wiser, more humane, and more effective treatment of narcotics addicts . . . ." He said the Senate was undoing the mistake of 10 years ago when it wrote legislation which made "super-criminals" out of many narcotics addicts.

NUMBER OF CHILDREN'S ASPIRIN BOTTLED IS LIMITED

AN INDUSTRY spokesman said drug makers and distributors will comply with a government request that the number of candy-flavored children's aspirin per bottle be limited to 25.

A LIMIT of 50 tablets per bottle was agreed upon in a government-industry conference in 1955 and has been observed by producers of 95% of all children's aspirin. However, some authorities consider this number now to be dangerous, even lethal under some conditions, when taken by a child.

INSTEAD of including a number-per-bottle limitation on children's aspirin in a "child protection" bill, the House Commerce Committee urged that the Food and Drug Administration seek voluntary cooperation from the aspirin industry. The spokesman said the industry would cooperate and that 25 one-quarter grains generally was accepted as a non-hazardous amount.

THE HOUSE AND SENATE approved differing versions of the legislation which would ban the sale of children's toys containing hazardous substances. It was left for a conference committee to adjust the differences.

BOTH VERSIONS also would ban dangerous household substances that cannot be made safe by cautionary labeling. These include such items as a flammable and explosive water repellant blamed for three deaths. ◄

a Private Psychiatric Center at Jacksonville, Illinois, *since 1901*

Complete psychiatric treatment in an environment for cure. A 50 bed hospital with the most modern diagnostic and therapeutic equipment for the treatment of nervous and mental disorders.

LICENSED: Illinois Department of Mental Health.
MEMBER: Illinois Medical Service (Blue Cross-Blue Shield).

Charcoal
Tip
A
Tareyton
20 FILTER
CIGARETTES
Tareyton
Tareyton...with the taste worth fighting for
America's largest-selling charcoal-tip cigarette
©The American Tobacco Company

How long will it take her to recover from her hip fracture if she just doesn't care?

Does she really care? Is she alert, encouraged, positive and optimistic about getting completely well soon?

Or has she given in to the demoralizing impact of confinement, disability and dependency?

When functional fatigue complicates convalescence, Alertonic can help...

Pleasant-tasting Alertonic is pipradrol hydrochloride—an effective cerebral stimulant whose gentle analeptic action helps counteract the apathy and inertia that can often delay convalescence—together with an excellent vitamin and mineral formula, in a satisfying 15% alcohol vehicle.

Nothing fosters confidence and a sense of well-being better than your own personal warmth, understanding and encouragement together with Alertonic to help insure prompt response.

Adequate dosage is important: Prescribe Alertonic—one tablespoonful t.i.d., 30 minutes before meals...tastes best chilled.

And for your patient's sake, prescribe Alertonic in the convenient, economical one-pint bottle.

Alertonic®

Available Only On Prescription

Each 45 cc. (3 tablespoonfuls) contains: alcohol, 15%; pipradrol hydrochloride, 2 mg.; thiamine hydrochloride (vitamin B_1) (10 MDR*), 10 mg.; riboflavin (vitamin B_2) (4 MDR), 5 mg.; pyridoxine hydrochloride (vitamin B_6), 1 mg.; niacinamide (5 MDR), 50 mg.; choline,† 100 mg.; inositol,† 100 mg.; calcium glycerophosphate, 100 mg. (supplies 2% MDR for calcium and for phosphorus) and 1 mg. each of the following: cobalt (as chloride), manganese (as sulfate), magnesium (as acetate), zinc (as acetate), and molybdenum (as ammonium molybdate).

*Multiple of adult Minimum Daily Requirement supplied.
†The need for these substances in human nutrition has not been established.

Indications: 1. Functional fatigue such as that often associated with: a depressing life experience or stressful time of life; advancing years; convalescence; limited activity or confinement. 2. Poor appetite and vitamin-mineral deficiency as they occur in: patients having faulty eating habits; geriatric patients who are losing interest in food; patients convalescing from debilitating illness or surgery.

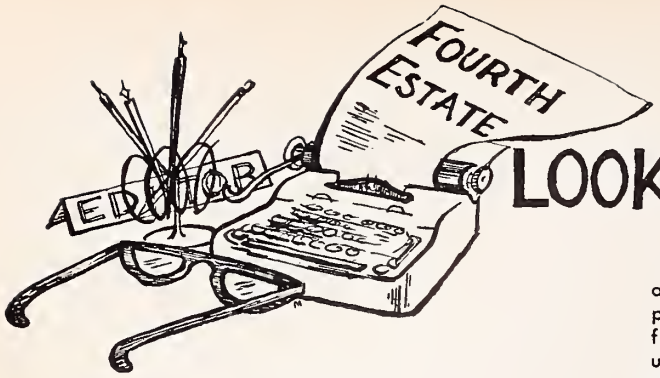
Dosage: Adults, 1 tablespoonful; children (over 15 years old), 1 to 2 teaspoonfuls; children (4 to 15 years old), 1 teaspoonful. To be taken three times daily 30 minutes before meals.

Contraindications: As with other drugs with CNS stimulating action, Alertonic is contraindicated in hyperactive, agitated or severely anxious patients and in chorea or obsessive compulsive states.

Side effects: Reports of overstimulation have been rare. Patients who are known to be unduly sensitive to the effects of stimulant drugs should be observed carefully in the initial stages of treatment.

Merrell

THE WM. S. MERRELL COMPANY
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215



LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

Russell Kirk Says:

Socialized Medicine Proves Giant Flop

Two decades ago, when the British National Health Service (socialized medicine) was established by Act of Parliament, the Socialist minister of health predicted that under socialism, the lives of English people might be prolonged indefinitely — such would be the strides of British medicine.

How about the reality, 20 years later? Today, both doctors and patients in Britain are puffing and shouting in indignation at the shortcomings (to put it mildly) of the scheme. Consider these facts, much discussed in the British press during recent weeks:

Over half a million English and Scots people are on long waiting lists for hospital services — and the backlog grows greater with every day that passes. People may have to wait seven years for treatment of hernias or varicose veins.

Hundreds of doctors, particularly the younger ones, are emigrating from Britain — more than a hundred in the past month alone.

Doctors are threatening to "work to rule," because there is small present prospect of their salaries being increased by the government. They receive no pay for overtime (unlike everybody else) and they have to pay for board and room if they occupy quarters at a hospital.

The present Labor Government insists that all prescribed medicines must be free — even a bottle of aspirin. This immensely increases the total cost of the Health Service, and is one reason why the Ministry of Health feels that it cannot increase doctors' salaries.

Recognizing that doctors are dreadfully overworked, the Ministry of Health recently decreed the curtailment of many hospital services, to reduce the burden upon doctors attached at hospitals. This, however, throws a corresponding load upon Britain's 23,000 general practitioners.

The needs of old people are especially pressing — and neglected.

Hypochondriacs and irresponsible people, who make unwarranted demands for medical attention in order to get their "money's worth," are recognized both by the British Medical Association and the minister of health as a major drag upon this system of state medicine.

Fewer promising students are attracted to medical colleges than formerly, and the prestige of the medical profession has diminished.

All this is a far cry from John Strachey's rosy expectations, 20 years ago, that Englishmen would become virtually immortal, here below, once the National Health scheme took on flesh. It is no more possible to "socialize" sound medicine than it is practicable to legislate good taste. — *The Indianapolis Star*, Sept 3, 1966.

It Can't Happen Here

It isn't likely, is it, that in the U. S. an agency of the Government would suggest to a company that its spending on advertising and promotion is excessive, and would recommend that such expenditures be cut almost in half?

To be sure, in Britain something of the sort has happened. But then, it has a Labor government. The British Monopolies Commission charges two producers of detergents — Unilever, Ltd., and Procter & Gamble, Ltd. — with spending too much on their advertising. It recommends they cut spending by at least 40%, on the grounds that if they do, there can be a 20% reduction in wholesale prices.

Now the commission's recommendation is not legally binding. But what it means is that the companies must enter into a sort of bargaining dialog with the British government, whether they want to or not. Understandably, the companies disagree with the commission's conclusions. They point out the obvious, which is that when properly expended, advertising funds result in lower distribution and unit costs than are possible, say, by spreading news about a product by means of a small army of doorbell ringers.

Moreover, it ought to be plain by now — as evidently it is not to the British Monopolies Commission — that unless product news is widely disseminated, as by advertising, the consumer is not alerted to the fact that there are choices available to him. And that there hardly can be a competitive economy in an absence of advertising.

For any governmental agency with the power to induce a reduction in advertising spending, and hence volume, surely has the power to bring about, if it chooses, the elimination of advertising. Which some people, who fret

Continued

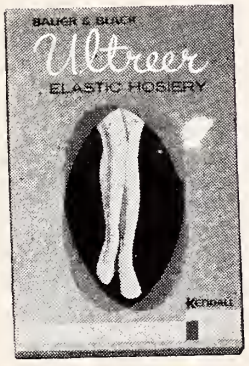
If you can't alarm her into wearing elastic stockings...

charm her with Ultreer™

You see, a woman simply has no defense against Ultreer Elastic Stockings. They look like lovely support stockings. They feel like lovely support stockings. They're that sheer, and shapely and comfortable.

But that's where the similarities end. New Ultreer fits firmly and evenly over the entire leg. Gives true therapeutic compression necessary to relieve varicose veins and other leg disorders. Each pair provides the therapy you prescribe. And at such a low price, a woman can afford two pairs of Ultreer as easily as she can afford one pair of ordinary elastic hosiery.

Ultreer. What a stocking.



KENDALL
BAUER & BLACK SUPPORTS DIVISION

Continued

about what they — and many Socialists — call the social cost of advertising, would like to see, together with packaging uniform in size, shape and color.

Here in the U. S., curtailment of advertising isn't being seriously espoused. Or is it? Well, a few weeks ago Donald Turner, chief of the Justice Department's antitrust division, said that it would be "quite appropriate" in circumstances where companies acquire "undue market power" through violation of antitrust laws, for the Government to "impose . . . an absolute or percentage limitation on promotional expenditures" even though such expenditures "were and are lawful."

He also proposed that there be some form of Government-operated or subsidized "evaluation" of consumer products "at lower social cost" so as to make consumers less dependent on advertising for their product news, and to help them "spend their dollars more fruitfully." That is, to spend them the way the Government thinks best.

What is happening to advertising and marketing in Britain can't really happen here . . . can it? — *Wall Street Journal*, Aug. 19, 1966.

Resistance to Drugs

Discovery in Europe that resistance to drugs can be caught by bacteria, as one catches a cold, has sent shivers down the spine of the medical profession. As *The New England Journal of Medicine* warns, "Unless drastic measures are taken very soon, physicians may find themselves back in the pre-antibiotic Middle Ages in the treatment of infectious diseases."

Tests in this country confirmed the finding that bacteria causing one disease can "catch" resistance to antibiotics from other types of bacteria. It helped account for the recent sharp rise in drug resistance.

Antibiotics routinely included in livestock feed has been found to promote development of the infectious form of drug resistance. Since resistance can jump from one strain of bacteria to another, it can jump from cattle to man. Hope for forestalling an epidemic of resistance lies, it is believed, in curtailing the use of antibiotics in agriculture.

It may come to a choice between saving the human species or the animals. When antibiotics are not used extensively, contagious resistance factors tend to die out. Since antibiotics are used in massive form in agriculture, its use must be curtailed there to save man. Simple as it may seem, it will depend on the cooperation of cattlemen and others, or compulsion by law if they do not cooperate. — *Marion Leader Tribune*, Aug. 16. 1966.

Mental Hospitals Discharging More Patients

The most refreshing news of the week was the word from Dr. J. R. Gambill, acting Indiana health commissioner, that the state's 11 mental hospitals are discharging 46% more patients than ten years ago.

Improved knowledge of mental health and a generally younger group of patients are credited with being the main factors in the improved record of the hospitals. The fact that there are more patients treated than a decade ago doesn't mean necessarily that more people are affected by mental disease — rather that the public is better educated to commitment, with a consequent better chance for cure.

It was not so many years ago that the State Mental Health Association started a program urging early recognition of mental ailments, and early commitment. There was a series of meetings with ministers over the state, and one of these meetings was in Vincennes. It started early-recognition education and understanding. There has been continued and broadened educational efforts since then, and the results are being seen in such reports as that of this week from the state health commissioner.

The battle, like all campaigns against sorrow, sin and frailty, is one that will never end, and will continue to progress only with constant vigilance and exertion. Tangible results, however, are pleasant to see. — *Vincennes Sun-Commercial*, Aug. 19, 1966.

Medicare Red Tape

One aspect of the Medicare bill when it was before Congress that troubled opponents of the idea was the amount of paperwork the program would involve.

Here in Indianapolis, such fears have been borne out. In fact, a "snowstorm of paperwork is accompanying the Medicare insurance programs here," according to *The News* reporter Charles McKinney.

One problem, McKinney notes, is that Medicare officials frequently change procedures in filling out the program's required forms. "It's hard to get used to the new forms," says Dr. Arvine Popplewell, administrator at General Hospital, adding that "we can hardly get" the additional clerical help needed to keep abreast of the changes.

McKinney reported that Community Hospital, too, has had paperwork problems and has had to hire additional clerical workers to process the Medicare forms. Doctors at Community complain the program requires them to sign a form certifying that each Medicare patient needs hospital treatment. Such procedure is ludicrous, the doctors feel, because the very admission of patients to a hospital indicates such care is necessary.

Additionally, Methodist Hospital has reported difficulty in paying monthly bills because it hasn't been paid for services provided Medicare patients.

Interestingly, all this trouble has occurred during just the first few months of the Medicare program and without any great rush to the hospitals by people over 65. Even under "normal" conditions, local hospitals and doctors involved in the Federal program find much of their time consumed with the avalanche of paperwork.—*The Indianapolis News*, Sept. 2, 1966.

Continued

UP TO 10–12 HOURS' CLEAR BREATHING ON ONE TABLET

Dimetapp® Extentabs®

(Dimetane® [brompheniramine maleate], 12 mg., phenylephrine HCl, 15 mg., phenylpropanolamine HCl, 15 mg.)

In sinusitis, colds, or U.R.I., Dimetapp lets congested patients breathe easy again. Each Extentab brings welcome relief all day or all night, usually without drowsiness or overstimulation. Its key to success? The Dimetapp formula—Dimetane (brompheniramine maleate), a potent antihistamine reported in one study to have elicited side effects as few as the placebo,* teamed with decongestants phenylephrine and phenylpropanolamine—in a dependable 10- to 12-hour form.

*Schiller, I. W., and Lowell, F. C.: New England J. Med. 261:478, 1959.

Contraindications: Patients hypersensitive to antihistamines. Not recommended for use during pregnancy.

Precautions: Until the patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.

Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability, or excitement may be encountered.

Dosage: 1 Extentab morning and evening, or as needed.

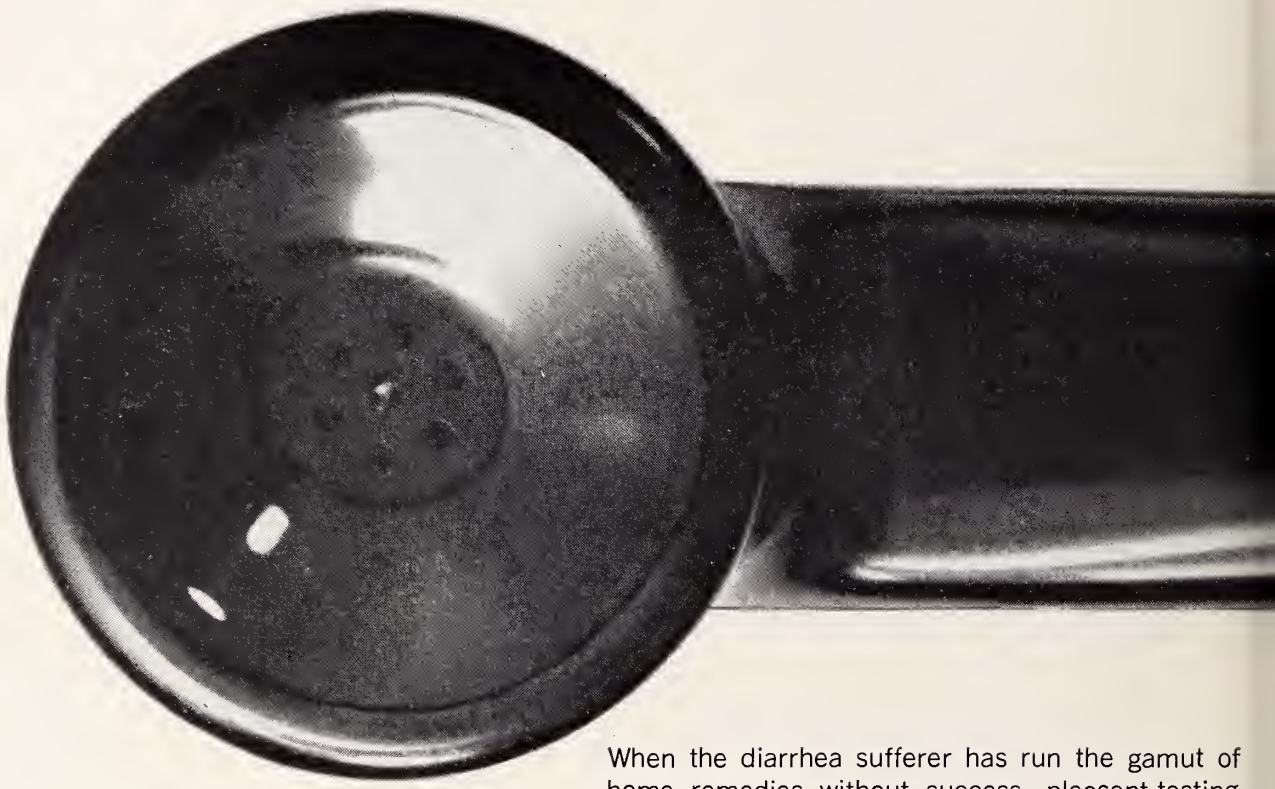
Supplied: Bottles of 100 and 500.

Also available: Dimetapp® Elixir for conventional *t.i.d.* or *q.i.d.* dosage. See package insert for further details.

A. H. ROBINS CO., INC.
RICHMOND, VIRGINIA 23220

A·H·ROBINS

When uncontrolled diarrhea brings a call for help



When the diarrhea sufferer has run the gamut of home remedies without success, pleasant-tasting CREMOMYCIN can answer the call for help. It can be counted on to consolidate fluid stools, soothe intestinal inflammation, inhibit enteric pathogens, and detoxify putrefactive materials — usually within a few hours.

CREMOMYCIN combines the bacteriostatic agents, succinylsulfathiazole and neomycin, with the adsorbent and protective demulcents, kaolin and pectin, for comprehensive control of diarrhea.

INDICATIONS: Diarrhea.

CONTRAINDICATIONS: Do not use in intestinal obstruction, extensive ulceration of bowel, or diverticulosis; in hypersensitivity to sulfonamides or neomycin; in pregnancy at term, in premature infants, or during first week of life in the newborn.

WARNINGS: Use only after critical appraisal in patients with hepatic or renal damage, urinary obstruction, or blood dyscrasias. Fatal hypersensitivity reactions and blood dyscrasias reported with use of sulfonamides. Consider periodic blood counts, hepatic and renal function tests during intermittent or chronic use.

PRECAUTIONS: Succinylsulfathiazole: Use with caution if there is history of significant allergies and/or asthma. Continued use requires supplementary vitamins B_1 and K. *Neomycin:* Watch for

your ℞ for Cremomycin can provide relief

curare-like neuromuscular block during anesthesia if neomycin is used preoperatively in large doses when renal function is poor; watch for overgrowth of nonsusceptible organisms. Consider possibility of ototoxicity and nephrotoxicity with prolonged high dosage.

SIDE EFFECTS: As with all sulfonamides: Headache, malaise, anorexia, G.I. symptoms, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, rash, conjunctival and scleral injection, petechiae, purpura, hematuria, and crystalluria have been noted. Reduced fecal output of thiamine and decreased synthesis of vitamin K have been reported. *Neomycin:* Nausea, loose stools.

Before prescribing or administering, read package circular with product or available on request.

promptly relieves diarrheal distress

Cremomycin®

ANTIDIARRHEAL

Composition: Each 30 cc. contains neomycin sulfate 300 mg. (equivalent to 210 mg. of neomycin base), succinylsulfathiazole 3.0 Gm., colloidal kaolin 3.0 Gm., pectin 0.27 Gm.

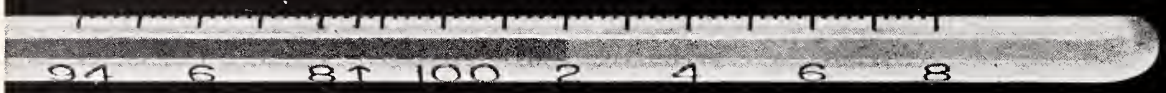
MERCK SHARP & DOHME Division of Merck & Co., Inc., West Point, Pa.

where today's theory is tomorrow's therapy

good reason to select Ilosone®

Erythromycin Estolate

for bacterial infections



two to four times the therapeutic activity of other erythromycins

CONTRAINDICATIONS: Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with preexisting liver disease or dysfunction.

SIDE-EFFECTS: Even though Ilosone is the most active oral form of erythromycin, the incidence of side-effects is low. Infrequent cases of drug idiosyncrasy, manifested by a form of intrahepatic cholestatic jaundice, have been reported. There have been no known fatal or definite residual effects. Gastro-intestinal disturbances not associated with hepatic effects are observed in a small proportion of patients as a result of a local stimulating action of Ilosone on the alimentary tract. Although allergic manifestations are uncommon with the use of erythromycin, there have been occasional reports of urticaria, skin eruptions, and, on rare occasions, anaphylaxis.

DOSAGE: *Children under 25 pounds*—5 mg. per pound of body weight every six hours. *Children 25 to 50 pounds*—125 mg. every six hours. *Adults and children over 50 pounds*—250 mg. every six hours. For severe infections, these dosages may be doubled.

Available in Pulvules®, suspension, drops, and chewable tablets. Ilosone Chewable tablets should be chewed or crushed and swallowed with water.

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The Journal
of the INDIANA STATE MEDICAL ASSOCIATION
Supervised by The COUNCIL
Volume 59 — November 1966 — Number 11

A new nasal decongestant, Afrin, in ear, nose and throat office practice, produced satisfactory results in 48 of 50 patients. There were no untoward effects.

Evaluation of a New Topical Nasal Decongestant

ARTHUR J. KUHN, M.D.
Munster

THE NEED for nasal decongestion in otorhinolaryngology, and the problems associated with many decongestants, has led to this report which is part of a continuous comparative evaluation of new preparations of this type as they become available.

Rebound congestion and growing tolerance, as well as irritation of the nasal mucosa, have been associated frequently with topical solutions for decongestion. Although topical preparations would be ideal from the point of view of easy use and relative freedom from systemic effects, the undesirable effects have made otolaryngologists cautious.

We recently tested a new topical nasal decongestant in the Kuhn Clinic which, during the experience to be reported below, proved to have many of the properties of an ideal preparation of this type.

Pharmacological Data

Oxymetazoline hydrochloride (Afrin ®)* is the most pharmacologically active of the imidazoline derivatives. It is sympathomimetic, and acts selectively to cause vasoconstriction of the nasopharyngeal mucous membrane. It has no effect on the cardiovascular or central nervous system.

Because the effect of oxymetazoline is local, and because it is highly effective in low concentrations (1:2,000), its safety and value are predictable. Extensive pharmacodynamic studies[1-8] have revealed virtually no rebound congestion, intolerance, irritation or other untoward effects associated with the use of this drug.

Spray containers and nasal solution are available. Administration twice daily is usually sufficient to maintain comfort. In very severe congestion, it is recommended that oxymetazoline be instilled twice in ten to 15 minutes initially, to relieve congestion deep in the turbinates near the ostia of the sinuses and eustachian tubes. The relief thus obtained should continue for several hours. For these reasons, repeating the medication in the manner just explained might be particularly helpful in treating the otitis media so often associated with upper respiratory infection.

Methods

Patients' opinions and observations of the practitioner were combined to grade results as excellent, good, fair or poor. The group studied was composed of 50 patients who ranged in age from ten to 73 years. There were 33 male and 17 female patients. Diagnoses included a variety of otolaryngeal conditions. Acute and chronic infections were treated, as well as vasomotor and chronic allergic rhinitis, sinusitis and rhinitis resulting from injury. There also were patients with otitis media, and some who had "dry nose" syndrome. The duration of illness varied from a few hours, in the case of nasal injury, to several years, as in the chronic allergic conditions.

There were 27 patients who used drops; 23 used the spray. Of the 50 patients, 26 used oxymetazoline more than three times daily, usually four times a day. The preparation was used three times a day by 16 patients and twice daily by eight. None repeated the medication soon after initial use.

Adjunctive medication was used occasionally to treat infection. No decongestive drugs except oxymetazoline were used during the period of observation.

Results

Action began within 30 minutes

*Product of the Schering Corporation, Bloomfield and Union, New Jersey.

after instillation for all of the patients. In the majority of patients (38) relief lasted more than four hours. One patient experienced beneficial results for more than eight hours, while the others (11) obtained relief for more than two hours but fewer than four.

Results were satisfactory in 48 (96%) of the subjects (Table 1). The two fair results were obtained in one patient believed to have a nasal tumor with secondary infection and in one patient who had persistent dryness of the nose. Other results were successful and encouraging. Oxymetazoline seemed equally effective for all of the disease processes represented among these patients.

DEGREE OF RELIEF

Effect	Number of Patients
Excellent	9
Good	39
Fair	2
Poor	0
Total	50

TABLE 1

Fractures of the nose were treated in two people, but the results in both of these cases were impressive. Oxymetazoline reduced edema both before and after repair of the injuries.

The allergic conditions and sinusitis often are associated with sensitivity and hyperirritability of the nasal mucosa when topical medication is used. There were no complaints of such drug-induced irritability among the 50 patients studied.

Some comparisons with other decongestants were made. Of the 23 patients in this group, ten said that oxymetazoline was better than other preparations used previously and 13 said that it was at least as good. One woman with a long history of nasal congestion said that the oxymetazoline nose drops were the best she had ever used. There were eight patients who had not been given decongestants before. Comparative information was not recorded in 19 cases.

The mildness of vasoconstriction and the duration of it were particularly impressive from the examiner's point of view. There was no instance of significant engorgement, rebound or development of intolerance following administration of oxymetazoline, nor were there any systemic effects.

Summary

A new nasal decongestant, oxymetazoline (Afrin®), was used in 50 patients treated during routine office practice. A wide age range and variety of diagnoses made the group representative of most problems in otorhinolaryngology. Of the 50 patients, 48 obtained satisfactory results and prolonged relief of symptoms. None experienced untoward effects. The evaluations of both observer and patients inclined to favor oxymetazoline over other similar preparations because of its safety and effectiveness.

REFERENCES

1. Eberhard, K. J.: Use of oxymetazoline in general practice, *The D.O.* 5:43-44, 1965.
2. Falkenberg, J.: Klinische Erfahrungen mit Nasivin (Clinical experience with Nasivin), *Landarzt* 39:76-79, 1963.
3. Friedrich, R.: Behandlung der Rhinitis mit einem entzundungshemmenden Mittel (Treatment of rhinitis with an anti-inflammatory agent), *Arztliche Praxis* 15:1141, 1963.
4. Hotovy, R., et al.: Zur Pharmakologie des 2-(4'-tert. Butyl-2',6'-dimethyl-3'-hydroxybenzyl)-2-imidazoliniumchlorids (on the pharmacology of 2-(4'-tert. Butyl-2', 6'-dimethyl-3'-hydroxybenzyl)-2- imidazolinium chlorides), *Arzneimittel-Forschung* 11:1016-1022, 1961.
5. Kluger, H. A.: Erfahrungen mit einem neuen schleimhaut-abschwellenden und entzundungshemmenden Suspension fur Nase und Augen (Experience with a new mucodecongestive and anti-inflammatory suspension for the nose and eyes), *Hippokrates* 33:992-994, 1962.
6. Kuhnke, I.: Erfahrungen mit einem neuen schleimhaut-abschwellenden Mittel (Experience with a new mucodecongestive agent), *Ariztliche Praxis* 13:2693-2694, 1961.
7. Miller, J.: Oxymetazoline in allergic rhinitis, *Clin. Med.* 71:1561-1564, 1964.
8. Slodki, S. J., Montgomery, C. A.: Clinical comparison of oxymetazoline and ephedrine in nasal decongestion, *Current Therap. Res.* 7:19-21, 1965. ◄

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Smith Kline & French Laboratories. Philadelphia

Psychiatric consultation is a time-consuming and relatively scarce service. It should be used as selectively as possible. Dr. Kuehn discusses the indications and contraindications for referral of patients to a psychiatrist.

Who Can Use Psychiatry?

JOHN L. KUEHN, M.D.
Baton Rouge, La. *

VARIATIONS on the theme "how best to make use of the psychiatrist's skills" continue to plague many in the practice of medicine. Frequent complaints that the psychiatrist is not accessible enough, that patients are dissatisfied with the psychiatrist's services or that the psychiatrist doesn't *really* help with "problem" patients. continue to occur.

There *are* significant limitations to the psychiatrist's usefulness. even with patients who are severely disturbed and badly "need" help.

Perhaps you have heard the analogy dividing patients into two groups — the "onions" and the "garlics." The person who eats onions is acutely aware of a distasteful odor to his breath, but in reality is not too annoying to others around him, despite his own discomfort. On the other hand, one who eats garlic can be most noxious to those in his immediate vicinity while "comfortable" and unaware he is disturbing to others. In my experience. many patients who have significant emotional disability belong to the "garlics." They seem fairly comfortable with their symptoms, *albeit complaining*, though most disturbing to and demanding of others, including their doctor. Many of the psychiatrist's referrals come from this group. i.e., those who have been annoying but don't really wish to change *themselves*.

Another problem is that general physicians often have difficulty accepting the fact that there are certain people for whom we have no special help, despite our skills and humanitarian aspirations. These are the individuals whom life has, indeed, treated badly. Simple physical survival and the hideous realities of day-to-day existence place them beyond our ministrations, both medical and psychological. These people often develop secondary mental symptoms such as apathy, suspiciousness, psychosomatic problems and virulent hostility. Of course, we must still adhere to the Oslerian dictum to "comfort always" even if we have nothing else to offer.

The "Too Helpful" Physician

Another issue is that psychiatrists sometimes seem to approach problems differently than the general physician, and this causes confusion and uncertainty. Our training has impressed upon us that the most immediate and "obvious" response to a problem is not always the most effective over the long haul. This is particularly true if our action in response to the patient's complaints *tends to increase clinging dependent behavior* on the patient's part.

An example of this would be prescribing medicine that partially alleviates the symptom without following along with adequate diagnostic exploration, medically and psychologically. Under the tyranny of time, this sometimes happens to all of us. Such patients then tend to return over and over again to the physician, since they have not yet faced the realities of their "problem." This results in much wasted time on the part of both the patient and the physician and extensive long-term financial cost to the patient as well.

Another reason these patients return is that the physician is reluctant to say "I cannot help you" straight out, although this indeed be the case. This is because many physicians have very strong "helpfulness" needs psychologically, which tend to preclude use of such statements — unless the patient has something obviously fatal, such as intractable cancer.

Now positively speaking, there are three modalities of treatment which psychiatry can offer people with significant emotional conflict and resultant disability: somatic treatment (usually medication or E.C.T.), hospitalization with appropriate milieu and group treatment, and individual or group psychotherapy, which many patients call "the talking cure." Some of us like to add a fourth mode — "philosophic and theologic," but it is not my purpose to explore this further here. Often some combination of these modalities is indicated.

The term "psychotherapy" covers a lot of ground. In general, I mean any encounter between human beings wherein one is identified as a professional helper, and the other as someone to be helped, and there is a *collaborative* effort to bring to consciousness and to understand the realities of life so that human suffering can be borne more adequately. Many non-psychiatric

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physicians are extremely adept in the use of somatic therapy and hospitalization. So it is in regard to psychotherapy that the psychiatrist can most often contribute something "different" and most specialized in a total treatment plan for a patient.

Who Can Use Psychotherapy?

Unfortunately, not everyone can practically *use* psychological therapy even though they might "need" it. Psychotherapeutic work probably will be helpful to our patients if in evaluating their disturbance, we can conscientiously answer "yes" to most of the following questions:

1. *Is the person dissatisfied and uncomfortable?* This refers to the "onion" versus "garlic" issue mentioned earlier. The person who is not very uncomfortable ("anxious") has no particular reason to change the way he deals with other people around him or the demands of society, despite his symptoms, which for him are *less* uncomfortable than being anxious. Unfortunately, many people, with addiction and habituation problems seen so frequently in the general physician's office, fall into this category as well as many who have behavioral difficulties and somatic "complaints." Where we do attempt psychotherapy we may need to *increase their anxiety level.* This makes them initially more uncomfortable or sometimes "sicker." This is why many patients referred to us are later "unhappy" and complain about psychiatry to their family doctors. They feel "the psychiatrist made me worse," and don't wish to return.

2. *Is he defeating himself by what he is doing?* Does the symptom interfere with his ability to work, provide appropriate satisfactions to his wife, children and other loved ones, or in some way keep him from gratifying reasonable wishes and participating in activities which give pleasure? If the symptom is not really interfering, motivation is often poor for psychotherapeutic work. Of course some people are not aware their behavior is self-destructive and need this pointed out to them by their doctor.

3. *Does he feel at least partly to blame for his difficulty?* A person who is able to blame his problems on other people or to an inordinate degree on the vicissitudes of life is a difficult candidate for the psychiatrist to help. Oftentimes the physician can be extremely helpful to this patient by confronting him with this phenomenon — that maybe he is tending to blame others for what is basically *his* problem.

4. *Does he have some ability to talk and communicate ideas, however limited?* I think it *is* true that the usual psychotherapeutic activity requires a minimal amount of ability to communicate in words, as well as by actions. There is also some need that the patient can make himself understood to the doctor and that the doctor can convey new ideas, or different ways of looking at life back to the patient successfully. This emphatically does *not* mean that the patient has to have achieved a certain level of education (such as college, professional status, etc.) in order to be helped by psychotherapeutic work.

In fact, there are some studies which indicate the intelligent but unsophisticated person utilizes psychotherapy better than the extremely well-educated person or the person of very high socio-economic level, who may use intellectualization as a paralyzing defense against coming to terms with what is really bothering him. In this latter group, I would put many of the people who come in and say they can *only* be helped by "psychoanalysis" or some equivalent time-consuming process.

5. *Is the patient free from serious "reality" problems?* Where people are living in slums, or do not have enough money for some minimal, civilized level of survival, or where demands for financial and other kinds of support are placed on them by others, the psychiatrist will have great difficulty in working with these people to focus on *intrapsychic* and *interpersonal* difficulties rather than the *day-to-day pain of basic existence.*

6. *Is the patient not only willing to ask for help in problems of living, but also willing to work on a problem himself, and not to expect the psychiatrist to do it alone?* It takes a certain kind of courage to say, in essence, I have difficulties in my life that are partly my responsibility. It takes courage to *allow* oneself to be helped. This is particularly true of men, who feel somehow it is not manly to admit they have been ineffective in problem-solving in their own lives. By the same token, it takes a certain kind of courage and independence to collaborate actively in psychotherapeutic work.

Many people who come to the doctor expect *passively* to be helped just by coming in. The model for this is the patient who has a sore throat and to whom we then give a shot of penicillin without further involvement. Psychiatry is an art and science within the practice of medicine which says to the patient, "You *are* responsible ultimately for the course of your own life, and we as physicians cannot 'make you well' without your active collaboration and involvement in the process of psychotherapy." Of course, we have a responsibility to teach our patients how to collaborate when we are in the beginning stage of treatment.

In this regard it is useful to view the psychotherapeutic process as catalytic. The patient basically has the resources already to change himself, but the psychiatrist through his skills serves as a catalyst which allows the patient's life process to "go" in the direction of health and growth as a human being.

The Patient Who Can't Use Psychotherapy

Practically, many patients will not be able to *use* psychotherapy. However, there are other agencies in our society, and there are other modalities which may be useful. Medication, hospitalization, social agencies, vocational training programs and various ac-

tivities in the field of education may be of much more explicit and practical value than dynamic psychotherapy. We realize the quality and quantity of these resources varies tremendously from location to location.

Sometimes the psychiatrist can be most useful to the general physician by supplying support, reassurance and specialized information about non-psychotherapeutic resources.* The physician should feel free to utilize both formal consultation (in which he tells the patient to go to the psychiatrist for one interview without the expectation that the psychiatrist will continue to see the patient) and "curbstone consults," utilizing that truly amazing instrument, the telephone.

Psychiatrists are very happy to discuss such things as resources, medication, etc., briefly with other physicians, even though it may not be practical to see the patient himself. *Non-psychiatric physicians should not feel reluctant to call on us for this kind of help.* Indeed, the Community Mental Health Clinic concept explicitly allows for and encourages such communications. We hope that non-psychiatric physicians will increasingly use such clinics as sources of information much as they now use "poison information centers" which are present in many hospitals in this country.

Finally, I would reiterate that many problems of people coming to us for help *are not solvable by the medical profession or any other existing agencies.* An example of this is the absence of adequate treatment facilities for mentally ill children and adolescents in many states. It may be that we will do most for these patients by gently confronting and comforting them about the realities and responsibilities of human life, while realizing that the ultimate answers will have to come from enlightened politicians, hopefully close to the grass-roots community level. ◄

*If a physician is interested, we will, of course, help him with counseling tactics or brief psychotherapeutic maneuvers *he* himself can use with the patient.

About Our Cover

The first week following an acute myocardial infarction is a time of intense watchfulness and care. The vast majority of deaths following an acute attack occur within this week from cardiogenic shock, cardiac arrhythmias or cardiac failure.

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This month's Hospital Practice on page 1350 features an article on the coronary care unit at St. Vincent's Hospital.

Our thanks to Methodist Hospital for providing the high contrast line diagram on this month's cover and also to the American Optical Company for providing us with a picture of its Lown Cardioverter Model No. 10770R. — J.F.S.

Suicidal tendencies are usually temporary and amenable to treatment. Recognition of the tendency, prior to an overt act, and prompt therapy will save many lives. This responsibility applies to all doctors.

The Clinical Assessment and Management of the Potential Suicide

IVER F. SMALL, M.D.
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*Indianapolis **

THE recognition of suicidal intent is a demanding and difficult responsibility for all physicians. With 20,000 recorded deaths by suicide each year in the United States and an estimated unrecorded total of 75,000 to 100,000, suicide remains among the ten top causes of death.[3,6,11,16,17] There is a growing demand by those alarmed by this high rate of self-destruction that means be provided to recognize the potential action of suicide. Increasingly physicians are asked to decide in reference to a particular patient, "Is he suicidal?" Emergency situations at the doctor's office, the hospital's emergency room, the suicide prevention center or at the patient's home may press the doctor to answer this question after only a brief interview or even following a simple telephone conversation.[1,2,6,13,15,24,27] The subject of this report is a review of the clinical assessment of suicide potential.

Diversity of Motivations, Methods

Complex reasons motivate the self-destructive act. A reliable clinical check list for predicting who will and when they will commit suicide is made most difficult by the diversity of motivations for the action and the variety of preferred methods of carrying it through. Among the reasons for suicide are the influences of the culture in which the patient lives, the meaning of these forces in relationship to the personal and developmental history of the patient, the "popular" method of the day and the state of the patient's physical health. Such diversity makes the recognition of the danger of suicide so difficult that of the 20,000 persons killing themselves annually, nearly 4,000 of them have been seen by a doctor for some type of medical problem during the week of their suicide. Accurate identification of suicide potential, therefore, remains a clinical skill of high order, and one that requires diligent effort for even partial mastery.[1,2,11,14,18,19,26] Table I outlines the clinical clues used for this assessment, and each is described in detail in the text.

Assessment of the Potential Suicide

I. The Identifying Data

Routine identification data about the patient can often be obtained relatively quickly. This information should provide the groundwork for the appraisal of potentially suicidal persons.

A. Age. Suicide is rare in children under five years of age; but, if it does occur, it is usually associated with violent, acting-out behavior. Strong, poorly controlled, hostile, aggressive emotions may then be clues to the possibility of self-destruction.[20] As with adults, children who have lost hope or who labour under serious duress are the most prone to suicide.

In early adolescence, suicide is again rare and not a readily predictable event.[3,18] When it does occur, there may be no indication the person is so disturbed that he intends to kill himself. For example: a typical case history involves a minor but frustrating, event as a precipitant stress —

> Mary, age 14, without previous history of difficulty, argued with her mother when not allowed something she wanted. During the argument, she announced she wanted to die. Shortly thereafter she went to the bathroom, locked the door, and took a potentially lethel overdose of medication.[24]

CLINICAL DATA FOR ASSESSING SUICIDE POTENTIAL

I. The Identifying Data
- A. Age
- B. Sex
- C. Marital status
- D. Religion
- E. Race
- F. Social class

II. The History
- A. Presenting situation
- B. Past history

III. The Patient's Mental Status
- A. Affective responses
- B. Content of thought
- C. Sensorium
- D. The life circumstances

TABLE I

*From the Department of Psychiatry, Larue D. Carter Memorial Hospital, Indianapolis. Dr. DeArmond is a resident in psychiatry; Dr. Small is Assistant Superintendent (Medical) and Associate Professor of Psychiatry.

Among young adults and college students, suicide is more common and ranks second after accidents as the leading cause of death.[3] Patients in this age group present with serious situational stresses for which they are ill prepared to cope and/or chronic problems of control of impulses with associated stress factors. In middle-aged and older adults, the act of attempted suicide is potentially much more lethal.[3,16,18,19] The middle-aged adult who is depressed, finding that life has lost its savour or that the dreams of youth are never to be fulfilled, is liable to see death as a pleasant end to a useless life. The aged person who finds himself alone, of no use now, unable to influence people as he used to and whose relatives and friends have preceded him in death is also a serious suicidal risk. In both the mid-adult and older adult age ranges, there is a propensity to try again if unsuccessful the first time. In more than half of all suicides, the age of the victim is 45 years or more. For both age ranges, the degree of risk is greatly increased during any time that the sensorium is clouded.

B. Sex. Four men are successful in killing themselves for each woman who cuts short her existence.[3,6,19] For suicide attempts, the ratio is the reverse. Only during adolescence are deaths by suicide more common among females than males. As age increases, so does the ratio of the number of men to the number of women who kill themselves. Farberow and Shneidman state, "We have rarely encountered a nonlethally intended suicidal action in a man over 50." Persons in this age and sex group are categorized as high risks in assessing suicide potential. When a man past 40 threatens suicide, an emergency situation exists. If an attempt of self-destruction occurs, it is likely to be deadly serious.

C. Marital Status. Statistical studies [3] indicate that successful suicides are higher in frequency in the unmarried or childless married persons over the age of 25. Divorced persons are reported to commit suicide more often than married, widowed or single people. The higher incidence of deaths by suicide in the divorced and unmarried groups is believed to be related to loneliness, coupled with a lack of commitment to specific goals in life and some inability to form personal relationships of deep meaning. This concept is related to Durkheim's theory of "anomic suicide" where there is "society's insufficient presence" in individuals who lack the regulating and influencing effect of an internalized social environment on their activity. It is characteristic then of the well socialized man that he learns to dampen the extent of his emotional responses and temper them to supply energy for his own useful purposes. Such learned and purposeful behavior is considered to be protection from the possibility of suicide as well as being associated with the type of person who chooses the close ties of marriage in preference to the single life.[4]

D. Religion. Suicide rates are higher among Protestants than among Catholics. While it has been suggested that strong ties with religion, and the support given by its authority and doctrine of faith, explains the decreased rate of suicide among Catholics, varying rates in different Catholic countries argue against such a simplified explanation.[3] Furthermore, Jews who also have strong family and religious ties show variable rates of suicide in different countries. Unfortunately, for more convincing evidence, we do not have figures on suicide for Jews born elsewhere but in Israel.[10] The diversity of possible interactions between individuals, their religious faiths, what their faiths mean to them and their involvement in these beliefs, challenges simple correlations. Because the factors of personal significance and meaning are not reported in the studies on suicide rate and religion, their usefulness in the clinical assessment of the potentially suicidal patient is limited.

E. Race. The rate of suicide per hundred thousand and the personal risk of suicide is different for different races.[3] In the United States, suicide rates are found to be three times higher among whites than Negroes, and ten times higher among non-whites other than Negroes. Oriental people especially contribute to this latter higher figure.

F. Social Class. Studies indicate that suicides tend to be higher in frequency at the extremes of the social and financial scales.[3] These trends are not too marked, and are usually considered to be due to the fact that these social classes deviate considerably from the main stream of the life of most citizens of this country, so that the ordinary social curbs, behaviors and mores may not be operating.

II. The History

When the physician is taking a medical history, there are certain groups of facts and circumstances which are important when evaluating the danger of suicide. Robins, writing on suicide, states: " . . . it is a premeditated act of which the person gives ample warning."[20] Warnings usually do exist and a review of the presenting situation and past history should offer clues which will aid in recognizing suicidal intent. The first warning is that an individual has come to an impasse in his life. It may be incurable physical disease, loss of position or death of a loved one, but the basic feature is a group of circumstances that mean disaster. The person has no control over these circumstances and no way out of the unhappy situation.

A. The Presenting Situation. Communication of the warning does characterize a significant number of suicides. One study reports that 68% of a group of persons committing suicide communicated their intent. Yessler, who elaborated on the communication aspects of suicide, reports that persons who attempted suicide were less likely to leave notes than those who successfully killed themselves.[28,29] Although he did not attempt to correlate the type of communication with potential for successful suicide, he did report the importance of communication as a significant warning signal for actual self-

destruction. Elaborate plans made by a patient such as placing his financial affairs in order, making wills and tidying up other business interests also may offer clues of serious, high risk potential. The real meaning of the actions in these cases may be cloaked by the language of high moral intent, but an alert examiner should look for other signs of possible impending self-destruction. A recent loss of a loved one may also increase the danger of serious suicidal intent.

If a suicide attempt has been made and the patient is brought for evaluation of suicide potential, it may be helpful to consider the method used in the attempt. Outlined in Table II is an objective scale of lethality compiled by listing the ten most common methods of suicide in the United States and New York City.

Although this list and a concept of degree of lethality according to the method used may be helpful, its function is limited. Methods of suicide and their lethality vary remarkably. They are affected by culture: for example in Japan, where in 90% of complete suicides soporific drugs are used with good effects; by geography, where in the U.S.A. the east and west coasts differ considerably in the preferred mode of suicide; new drugs, such as barbiturates that make the messy affair of self-inflicted death more pleasant and are quickly adopted, or the "Marilyn Monroe syndrome" where the lethal method used by a famous personality may be used by others. A fixed list rating the lethality of methods does not take into account such factors. The list has been used by some who suggest that attempts made using methods high on the list of lethality indicate a greater risk and more serious suicidal intent than those low on the list.

Where the patient is examined by the physician may be helpful to consider. Evaluation over the telephone often involves patients who are impulsive, with poorly controlled behavior, and are making the now famous "cry for help." Assisting these people to control themselves until the impulse passes can be lifesaving. If seen in the emergency room of the hospital, the patient has usually made an attempt at, or has been threatening suicide and concerned relatives or public authorities have brought him to the hospital. These patients have already mobilized some of their needed assistance.

Anxiety and depression characterizes the typical patient being evaluated in the doctor's office. With these people, the degree of support the doctor offers may be the critical lifesaving deterrent. Hospitalized patients who are serious suicidal risks are those with depression with or without associated chronic physical illness and those with clouded sensorium. For this hospitalized group, emergency consultation and care is important, even without their threatening suicide. In each of the cited instances, the manifold factors preceding the attempt to kill is different, and the assessment of the danger and the planning of the treatment varies for each person.

B. The Past History. A knowledge of a past history of suicide attempts is helpful in assessing risk. Out of one study came a report that 75% of the subjects who killed themselves had made previous threats or attempts. A long, chronic history of repetitive suicidal rumination and behavior may indicate a poor prognosis. The person may be characterized as "rootless" and lacking purpose and direction. If there is no previous history of suicidal behavior and there is only a short history of difficulty, the long-term prognosis is better if the person is tided over the crisis.

A past history of emotional or physical illness, particularly chronic, debilitating disease, is associated with suicide. Robins, in his study, reports that 98% of the patients who committed suicide were clinically ill and 94% were psychiatrically ill.[20] Capstick reports that 78% of persons who committed suicide were under a doctor's care prior to death and that the most dangerous time seemed to be shortly after discharge from the hospital.[2] Others also report a "90-day danger period" for suicide following hospital discharge. That the relatively high rate of suicide following hospitalization may represent missed diagnosis, premature release from medical care, or new and altered stress factors in the environment, is not dealt with in these articles.

COMPARISON OF POPULAR METHODS OF SUICIDE

	United States Suicides	New York City Suicides
Most Frequent 1.	Firearms and explosives	Gases
2.	Poisons or gases	Hanging
3.	Hanging	Jumping from high places
4.	Drowning	Poisons
5.	Jumping from high places	Firearms
6.	Cutting or piercing instruments	Cutting or piercing instruments
Least Frequent 7.	Other	Other

TABLE II

III. The Patient's Mental Status

A. Affective Responses. Feeling states of depression are commonly associated with suicide. The signs of depression, such as insomnia, anorexia, somatic complaints, verbal expressions of guilt and self-depreciation, a lack of vitality and sexual impotence or frigidity are important warnings, too, and may even exist without awareness of the depressed affect.

The patient in severe depression reaches a level where the psychomotor

retardation acts as an inhibitor of action and therefore is a temporary protective device. At that point, the patient may not have the energy to carry out any suicidal intent. During the period when the patient begins to improve, and the inhibition of psychomotor retardation is lessened, the danger of suicide may be quite high. This is a phenomena particularly to be watched for during early response to ECT or drugs. Sudden improvement in a depressed, hopeless or delusional patient may increase the risk of suicide. Sudden changes of affective tone, such as depression — "what's the use" or elation — "I have solved all my problems" should be regarded as worrisome signals to the physician.

B. Content of Thought. Among the most indicative expressions of the potentially suicidal patient are those of hopelessness, exhaustion and failure: "I just want out." Concern with lack of ties and isolation, "No one loves me," also may characterize the thought of the potentially suicidal person. Preoccupation with thoughts of shame, hate, fear and pessimism about the future with ideas of death and suicide are signs of possible self-destruction.

Acute but not chronic psychosis with disorder of thought content is reported to increase significantly (four to nine times the control rate) the danger of suicide. For example:

> A 41-year-old white male, married, had delusions of persecution. He repeatedly stated that someone had it in for him. He saw his room as a gas chamber and the overhead light as an x-ray. His delusions continued; he became intent on reading the Bible, and later, with little change in his behavior, went outside and shot himself to death.[6]

Mental illness significantly increases the risk of self-destruction, and Farberow reports a high incidence of reactive depressions among patients who have committed suicide.[5,12] Henderson cites this example:

> A 32-year-old white female, single, was depressed and preoccupied with wanting to die. She was sleeping poorly and had a loss of appetite. Her motor behavior was slowed and she was described as "enveloped by her own misery." She expressed, "Life is dead for me; my universe is shattered. The pain is always with me." She seemed to improve somewhat on medication but shortly afterwards, killed herself by drinking Lysol.[7]

Robins reported in his study of hospitalized patients that 68% of the persons killing themselves had one of two illnesses: manic-depressive psychosis or chronic alcoholism.[20] He suggests concentrating on preventing suicide in these two groups and emphasizes the potential danger in a patient having either of these illnesses who communicates suicidal intent.

C. Sensorium. Patients with clouded sensorium are a dangerous suicidal risk, as they are notorious for not giving warning of their intention to kill themselves. One study reports this case:

> A 26-year-old Negro male, single, was admitted to the hospital with abdominal complaints. On the second day he was nocturnally agitated, delirious and confused. On the fourth hospital day, without other warning, he killed himself by jumping from the third floor window.[23]

For hospitalized patients, any person who has a toxic delirium, or a state of reduced perceptual alertness should be considered as a suicidal risk and appropriate remedies applied. In nonhospitalized patients, MacDonald and Selzer have both noted increasing suicide attempts and automobile accidents in those who are heavy drinkers.[17,21]

D. The Life Circumstances. An understanding of the "significant other" and its relationship to the patient should be sought in an initial evaluation of suicidal potential. Self-destructive acts are rarely felt to be solitary, and the communicative aspects are repeatedly stressed. In general, if the relationship between the patient and the environment has facilitated communication and has acted positively in meeting personal needs, then the potential of suicide is reduced. If, however, the relationship has inhibited communication and decreased gratification, the danger is correspondingly increased. The danger is grave when an impasse with life events is reached and no solution presents itself.[28,29]

Management of the Potential Suicide

In most instances, the handling of a patient with suicidal intent or one who has attempted suicide follows routine basic medical principles. If the body has been wounded, then it is treated in the regular manner. Psychotic depressions respond well to the medical treatment of electroconvulsive therapy and may also respond to mood elevating drugs. Mildly depressed persons who are anxious, tense and fearful have for centuries been supported by the kindly interest of the doctor-patient relationship, supplemented with medication to tide over the difficult periods. If the basic problem is one of impulse control, then outside control needs to be provided for short or long-term periods. For patients with diminished powers of cognition and comprehension, complete care may be necessary until the return of normal intellectual function is achieved.

Society, too, provides much support for the unhappy, fearful or sick. In time of duress, it is common practice for families to unite and offer support. Public agencies operate round the clock to provide for those without family, the ill or otherwise needy. We have our rituals and customs, too, such as mournings, wakes and talk sessions, to help rid us of the surging energy of self-destruction that is associated with severe personal loss or shame. From both private and public sources, we have the potential for rapid support to be mobilized to help any person who suffers severe distress.

This is an impressive list of aids. However, one further addition may at times tip the balance for a lifesaving outcome. Offer to the patient a face-saving way out. This is an emergency treatment device, and to be effective, should be used at the time the pain of emotional suffering is most keenly felt

by the patient. In this type of emergency psychotherapy, the simple operating hypothesis is that the patient is angry, angry enough to kill, and can see no other reasonable or honorable action to take in his life situation. Behind this state of emotion and high drive are three common states of mind.

First — the patient whose mind is disordered and suffers from a "functional or toxic" psychosis. This may be combined with an emotional upset, usually depression or paranoia with or without delusions, or an alteration of sensorium with diminution of intellect wherein the deficit of memory is the most sensitive indicator.

Second — the patient whose behavioral control is chronically disordered. Here, the personal history is replete with instances of intemperate behavioral and emotional responses to mild internal or external events. When this patient suffers an acute fit of pique, there may ensue a state of tension which the patient has no means available to dampen, and the end result may be unendurable.

Third — is the patient who is in possession of all his faculties and in control of his behavior. Some catastrophic event has occurred in his life and cold analytic logic now makes it plain that life cannot continue as it will offer only pain and torment. These patients are often afraid to die, have deep regret concerning their departure but are insistent that there is no other decent thing to do.

When the physician is reasonably assured of the overt reasons for the distress, then the emergency talking treatment continues in order to establish for the patient the conditions under which (a) an immediate change of the purposeful self-destructive urge is possible, (b) a controlled verbal release of an aroused feeling state of anger is achieved, and (c) an acceptable outline of a more hopeful future is agreed upon.

The physician who supplies to a patient perched on a pinnacle of near homicide a face-saving alternate action usually wins a grateful patient who will then embark upon a longer course of treatment in order to restore a better balance to his life. However, the process of ventilating at the time of stress is a crucial one to immediately reduce anxiety, bind the patient to the physician and provide alternate methods of response. Blunt but tactful persistence is required of the physician to ascertain the personal factors behind the emotional state.[6,8,9,14,17,19,22,25]

Summary

This paper has reviewed the clinical assessment and the management of patients who can be considered potentially suicidal. Such pertinent assessment factors as the identification data of the patient, the present and past history, the mental status of the patient and the relationship between the patient and his environment have been noted and their association with the act of suicide discussed.

The points are made that the almost unique qualities of each individual suicidal act defies too much generalization of our knowledge. Every patient must be considered individually and in the light of his own life circumstances, emotional responses and patterns of behavior. Further, because of the social stigma associated with suicide, many self-inflicted deaths are not recorded as such. Consequently, the validity of some statistical studies may be questioned and the conclusions drawn may invite error, especially for individual cases.

In order to assess the danger for suicide, the physician needs to be fully cognizant of the complexity and variety of motivations which characterize suicide and suicide attempts. Then the full evaluation of each patient may permit assessment of suicidal intent with a reasonable degree of accuracy. Prompt treatment that emphasizes the patient learning new and more mature coping behavior may be lifesaving and an outline of the methods used to influence patients with words is sketched as a part of the general medical management. A physician who understands his patients and who works with them to find honorable solutions to vital life problems offers much hope in dealing with this deadly problem.

REFERENCES

1. Bunney, W. E., Fawcett, J. A.: Possibility of a Biochemical Test for Suicidal Potential, *Arch. Gen. Psychiat.* 13: 232-239, 1965.
2. Capstick, A.: Recognition of Emotional Disturbance and Prevention of Suicide, *Brit. Med. J.* 1:1179-1183, 1960.
3. Dublin, L. I.: *Suicide*, New York, Ronald Press Co., 1963.
4. Durkheim, E.: *Suicide*, (1st French ed., 1897) Glencoe, Ill., The Free Press of Glencoe, 1951.
5. Farberow, N. L.: Personality Patterns of Suicidal Mental Hospital Patients, *Genet. Psychol. Monogr.* 42:3-79, 1950.
6. Farberow, N. L., Shneidman, E. S., ed.: *The Cry for Help*, New York, McGraw-Hill, 1961.
7. Henderson, D., Batchelor, I.R.C.: *Textbook of Psychiatry*, London, Oxford University Press, 1962.
8. Hendin, H.: *Suicide and Scandinavia*, New York, Grune & Stratton, 1964.
9. Hendin, H.: The Psychodynamics of Suicide, *J. Nerv. Ment. Dis.* 136:236-244, 1963.
10. Hes, J. PH.: Manic-Depressive Illness in Israel, *Amer. J. Psychiat.* 116:1082-1086, 1960.
11. Hirsh, J.: Suicide, (Part 4, Predictability and Prevention), *Ment. Hyg.* 44:382-389, 1960.
12. James, I. P., Levin, S.: Suicide Following Discharge from Psychiatric Hospital, *Arch. Gen. Psychiat.* 10:43-46, 1964.
13. Kaphan, M. N., Litman, R. E.: Telephone Appraisal of 100 Suicidal Emergencies, *Amer. J. Psychother.* 15:591-599, 1962.
14. Kubie, L. S.: Multiple Determinants of Suicidal Efforts, *J. Nerv. Ment. Dis.* 138:3-8, 1964.
15. Litman, R. E., Farberow, N. L., Shneidman, E. S.: Suicide-Prevention Telephone Service, *JAMA* 192:21-25, 1965.
16. Martin, P. H.: Some Statistics on Suicide, *JISMA* 55:35-37, 1962.
17. MacDonald, J. M.: Suicide and Homicide By Automobile, *Amer. J. Psychiat.* 121:366-370, 1964.
18. Meerloo, J. A. M.: *Suicide and Mass Suicide*, New York, Grune & Stratton, 1962.
19. Pokorny, A. D.: Characteristics of 44 Patients Who Subsequently Committed Suicide, *Arch. Gen. Psychiat.* 2:314-323, 1960.
20. Robins, E., Murphy, G. E., Wilkinson,

R. H., Gassner, S., Kayes, J.: Some Clinical Considerations in the Prevention of Suicide. Based on a Study of 134 Successful Suicides, *Amer. J. Pub. Hlth.* 49:888-899, 1959.
21. Selzer, M. L., Payne, C. E.: Automobile Accidents, Suicide and Unconscious Motivation, *Amer. J. Psychiat.* 119:237-240, 1962.
22. Shaw, C. R., Schelkun, R. F.: Suicidal Behavior in Children, *Psychiatry* 28:157-168, 1965.
23. Shneidman, E. S., Farberow, N. L., ed.: *Clues to Suicide,* New York, McGraw-Hill, 1957.
24. Sifneos, P. W., McCourt, W. F.: Wishes for Life and Death of Some Patients Who Attempt Suicide, *Ment. Hyg.* 46: 543-552, 1962.
25. Small, I. F., Small, J. G., Fjeld, S. P., Hayden, M. P.: Organic Cognates of Acute Psychiatric Illness, *Amer. J. Psychiat.* 122:790-797, 1966.
26. Stengl, E.: The Complexity of Motivations to Suicidal Attempts, *J. Ment. Sci.* 106:1388-1393, 1960.
27. Tuckman, J., Youngman, W. F.: Identifying Suicide Risk Groups Among Attempted Suicides, *Pub. Health Rep.* 78:763-766, 1963.
28. Yessler, P. G., Gibbs, J. J., Becker, H. A.: On the Communication of Suicidal Ideas II, Some Medical Considerations, *Arch. Gen. Psychiat.* 5:12-29, 1961.
29. Yessler, P. G., Gibbs, J. J., Becker, H. A.: On the Communication of Suicidal Ideas I, Some Sociological and Behavioral Considerations, *Arch. Gen. Psychiat.* 3:612-631, 1960. ◄

Warning to Walkers

You're not immune to traffic accidents even when you're walking.

Nine thousand pedestrians were killed and nearly 275,000 were injured last year in the United States, according to an authoritative report by The Travelers Insurance Companies. The report is based on statistics from state motor vehicle departments.

Those who cross between intersections run the biggest risk of getting hurt. More than 40% of the fatal accidents and nearly 32% of all non-fatal mishaps involving pedestrians occurred between intersections.

Those who enjoy hiking in the country also should beware. One thousand, four hundred pedestrians were killed in 1965 while walking along rural roads; nearly 21,000 more were injured on country byways.

Other leading factors involving pedestrian death and injury included crossing an intersection against the traffic signal and stepping from behind a parked vehicle.

But The Travelers reports indicate you should exercise caution wherever you may be. Last year, for example, 300 persons were injured while standing on a traffic safety isle.

Second Look at New Drug Laws?

Many economists are convinced that the American system of patents and trademarks and brand names has been a vital factor in the great progress of the United States and its leadership in establishing a standard of living superior to that anywhere else in the world.

The factors involved include not only this system but also the right to advertise, the right to disseminate information, and the right to legitimate pride in distributing as widely as possible the benefits of new inventions and discoveries. How much time must pass before the ultimate effects of the new (drug) legislation become apparent is difficult to predict. The effects are only beginning to be felt. Perhaps the time is near when the legislators will have to take a second look. — Morris Fishbein, M.D., in *Postgraduate Medicine,* (39:205-206), February, 1966.

Animal Research in Danger!

The "animal protectionist" groups have mounted the greatest offensive against the effective use of animals in biological research and teaching that has ever been attempted in the United States. Today in Congress there are bills to which about 40 congressmen have attached their names, dealing with procurement, housing, care and use of experimental animals.

The present mood of Congress is to accede to the demands of the vocal animal protectionist minority and pass some sort of legislation. Every physician and biological scientist who has a sense of public responsibility should be informed of the issue and communicate his views to his congressman as to public harm that might be done by unwise legislation. — Maurice B. Visscher, Ph.D., M.D., in *Modern Medicine,* (34:87), March 14, 1966.

The Tenacles of Government Control

The new drug regulations were created because of certain problems which needed correcting. In an effort to be precise and encompassing, the wording was made all-inclusive. When interpretation and enforcement subsequently followed, it has been found now that not only was the total drug industry brought under complete government control, but also the whole of medicine. This means not only one phase of medicine, but the whole spirit of medicine has been made captive. — James H. Johnson, M.D., in *Annals of Allergy,* (24:88), February, 1966.

New Drugs But Old Problems

LSD and other psychedelic drugs to come suggest that some will be devised to have far reaching benefits upon perception, memory and mentation that may produce a new breed of man. . . . We are probably on the threshold of "well-healed" scientific inquiry into mind-memory learning, problem solving, thinking.

Attempts to understand the operations of the brain must produce knowledge whose impact upon our civilization may be immense. We must consider in advance how to deal with the ethical, political and social problems that may arise, if a real psychedelic drug comes into existence. — Louis H. Nahum, M.D., in *Connecticut Medicine,* (30:165), March, 1966.

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DORSEY Season

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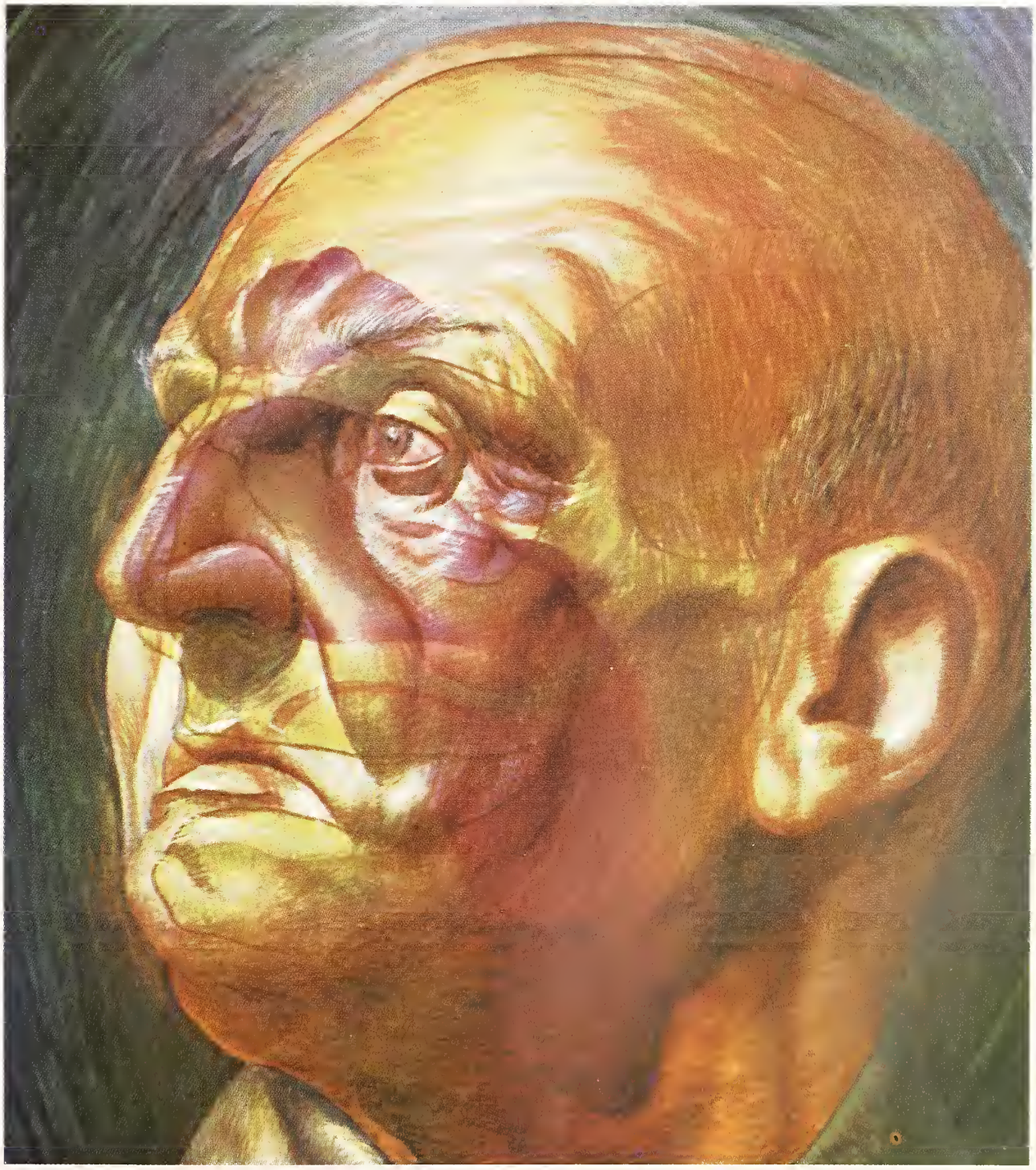
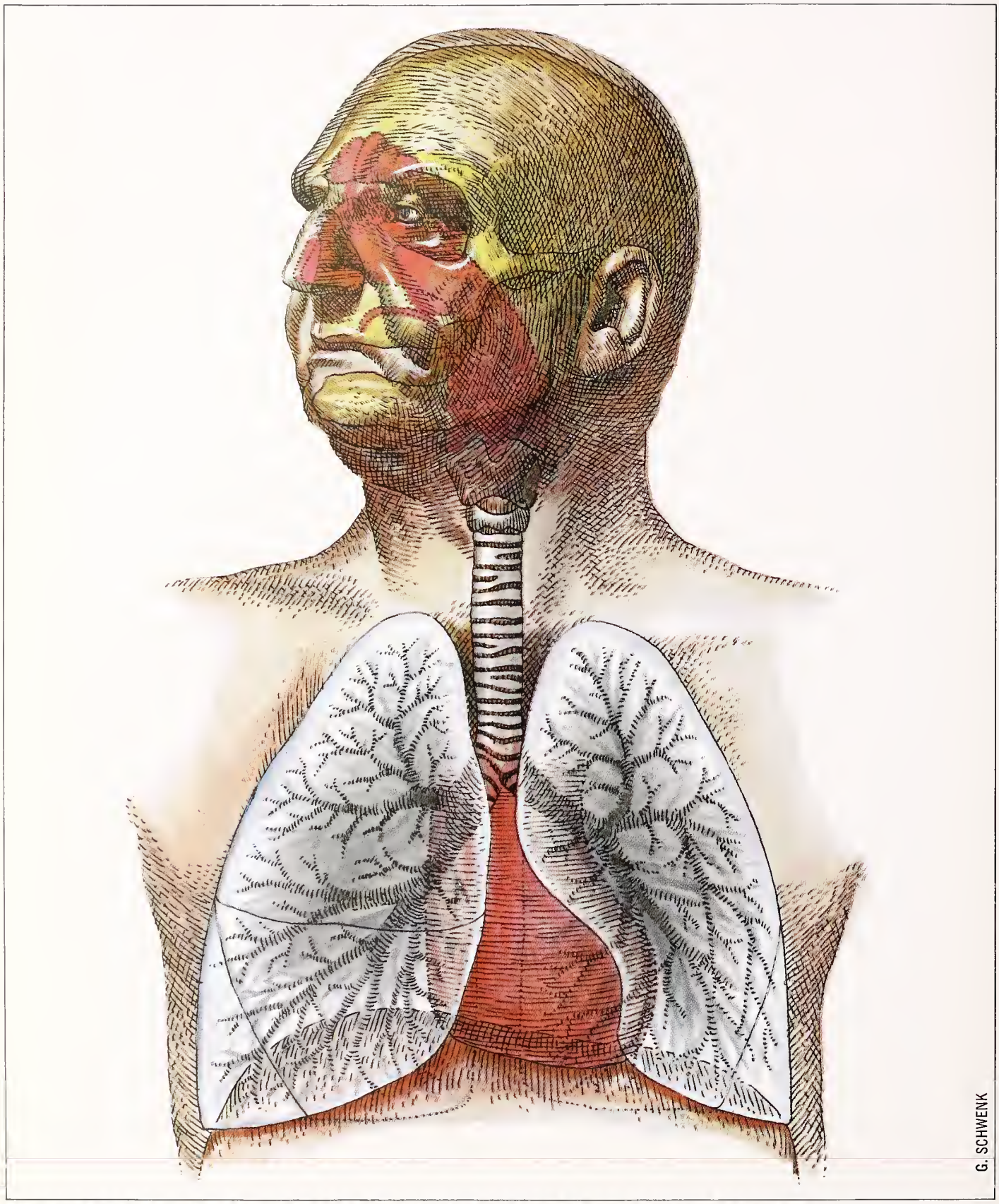


this issue: the common cold and the aging patient

the common cold and the aging patient

Louis J. Vorhaus, II, M.D., F.A.C.P.



Effects of aging on the anatomic and physiologic aspects of the respiratory apparatus.

The chest becomes more fixed, less mobile and less elastic as the bronchial walls and thoracic ligaments lose elasticity. The diaphragm and intercostal muscles atrophy and weaken. The lungs become smaller, flabbier and weigh less, decreasing vital and total lung capacity, increasing residual volume and the alveolar dead space.

Sir William Osler described pneumonia as the welcome friend of the aged patient, because the patient with pneumonia usually died quietly. But today, the well-informed physician is an even better friend of the aging patient, since it is better to live than to die, no matter how quietly.

One of the first avenues of approach in the control of the hazards of respiratory disease in the aging patient is prompt and proper attention to the common cold or upper respiratory infection. The common cold may be the first step in the relatively short path to lower respiratory infection, broncho-pneumonia and death. This train of events occurs frequently among older persons. Indeed, pneumonia is one of the most common causes of their admission to hospitals and ranks high on the list of geriatric killers. Colds are more debilitating in elderly people and the aged are more likely candidates for secondary infections such as sinusitis and bronchitis. These infections, in turn, are more prone to lead to bronchopneumonia, because of lowered resistance and anatomic and physiologic changes in the lungs of the elderly.

What is different about the respiratory tree of an aged person and that of an otherwise healthy younger adult? Aging certainly takes its toll on all parts of the body, affecting both anatomic and physiologic aspects of the respiratory apparatus. These changes are in part due to the wear and tear that occurs over the years; the repeated bouts of respiratory infection, long exposure to atmospheric pollutants, to occupational inhalants, smoking, malnutrition, obesity, inactivity and the development of other diseases which may affect the lungs.

With the passage of years, the lungs change. They become scarred and emphysematous and lose their compliance. The whole chest becomes more fixed, less mobile and less elastic.

The anatomic changes that occur in aging render the lungs less efficient. Tests of pulmonary function in senescence show a deterioration characterized by a decrease in vital capacity and total lung capacity, an increase in residual volume and alveolar dead space. Maximum breathing capacity is reduced and uniformity of ventilation deteriorates. These problems are often aggravated by the obstructed breathing, fever and secondary infection associated with the common cold, placing an additional stress on the entire cardiopulmonary reserve.

In addition, the efficiency of a cough is below par in older persons even though they are in good health. This is partly due to the decreased respiratory excursions and distensibility of the chest wall, and partly from loss of elasticity of bronchial walls which tend to make them collapse in a cough.

The elderly patient's resistance to infection is often reduced. Nutritional deficiencies are more common in aged people. There is some evidence to indicate that their capacity to respond to stress is less efficient. Finally, there is often relatively meager symptomatic response to acute disease. The absence of obvious or dramatic clinical signs and symptoms of severe illness is particularly dangerous because, coming as it

(concluded on following page)

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does in a person whose defenses are weakened both locally and systemically, pulmonary disease may progress rapidly to irreversible stages before medical attention is sought. Respiratory infection is especially hazardous because the aged patient responds badly to hypoxia. Not only is his response to oxygen lack impaired, but the work of breathing, due to decreased compliance of the lung and increased stiffness of the thorax, is markedly augmented.
Many patients late in life are in a precarious and delicate cardiopulmonary balance which is easily decompensated from relatively minor insults such as colds and upper respiratory infections.

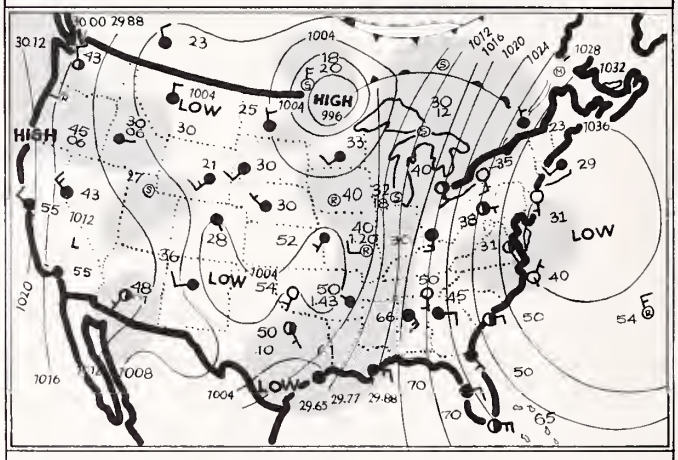
For all of these reasons, geriatricians long have stressed the importance of preventing respiratory insults. Today we have better ways of treating respiratory infection, improved techniques for clearing the lungs and bronchial tubes of secretions and better understanding of ways of improving ventilation. We possess a broader spectrum of antimicrobial agents including newer ones to deal with previously resistant organisms. Even so, the death rate from pneumonia is high in older people, and it is preferable to avoid the disease than to treat it. To do so, attention must be paid to the general maintenance of good health and all that implies, as well as to the prevention, elimination and treatment of associated conditions that predispose to or cause pneumonia such as chronic upper or lower respiratory infection, respiratory allergy, chronic sinusitis and exposure to inspired irritants.

Colds and other minor respiratory infections, which favor the development of broncho-pneumonia, should be treated vigorously and promptly, particularly those patients whose aging process has been accompanied by the development of chronic pulmonary disease. Upper respiratory passages should be cleared with decongestants. Sinuses should be drained adequately. And, when indicated, appropriate antimicrobial therapy should be instituted before serious infection of the lower respiratory tree supervenes.

In decades past it was understandable that physicians welcomed pneumonia for the aged patients because it offered them a quiet and peaceful demise. Today we recognize that in many cases, peaceful as it may have been, such deaths were often avoidable. With the current knowledge and understanding of the problems that respiratory infections impose on aging people, vigilant medical attention can often restore them to a vigorous, rewarding and productive life so that the many opportunities that exist today for people to enjoy their golden years are realized and not stolen by untimely death.

References 1. Steiglitz, Edward J., Geriatric Medicine, Medical Care of Later Maturity, 3rd edition, J. B. Lippincott Co., Philadelphia, 1954. 2. Norman, J. R., Schweppe, I. H., Salazar, E. and Knowles, J. H., Lung Volumes and Aging, Journal of the American Geriatrics Society, 12, pp. 38-47, January 1964. 3. Penman, Robert W. B., Hypoxia and Respiratory Failure, Geriatrics, 18, 807-814, November 1963. 4. Middleton, William S., Some Medical Dissections on Aging, Geriatrics, 18, 168-73, March 1963. 5. Cole, M. B. and Roberts, F. E., Clinico-Pathologic Study of Emphysema, Journal American Geriatrics Society, 12: 415-419, May 1964. 6. Horton, Glenn, Testing of Pulmonary Function, Geriatrics, 17:73-81, February 1962. 7. Banyai, Andrew L., Cough and its Management in Elderly Patients, Geriatrics, 14:621-630, October 1959. 8. Howell, T. H. and Piggot, A. P., Morbid Anatomy of Old Age, Geriatrics, 8:267-72, March 1953.

Weather Forecast Throughout the Nation



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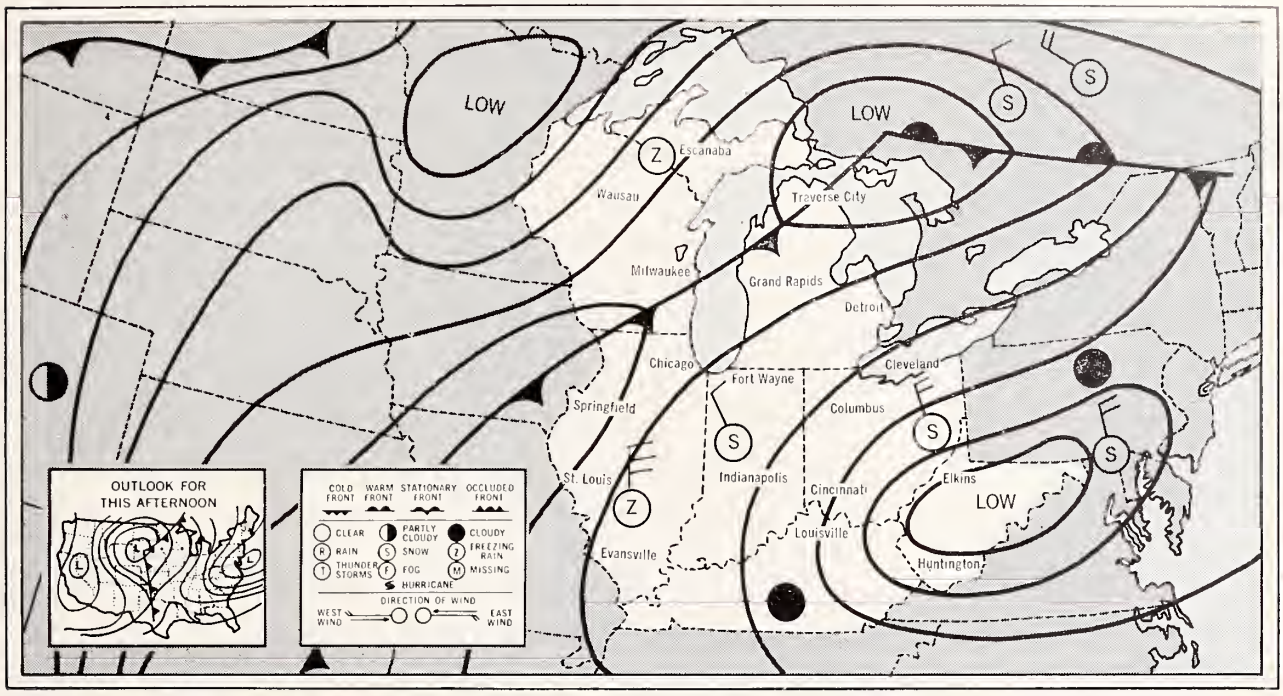

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The Case of Reverse Racism

ARNOLD LIEBERMAN, M.D.
New York, N.Y.

RACISM is a form of cultural chauvinism hinging on one central idea: one's own group is so *obviously* superior that it has an inherent right to rule over everyone else. The Chinese assert themselves to be "The Sons of Han": all other people are mere "foreign monkeys": a total snub to non-Han members of the Primate class. The ancient Romans gloried in the "Pax Romana"; Queen Victoria's subjects were very proud, indeed, of carrying the "white man's burden" to the far corners of the globe. The Germans, under both Kaiser Wilhelm and Hitler, fumbled the Teutonic "Übermensch" concept most ineptly.

The pious provincials colonizing North America quoted Scripture even as they exterminated the resisting "Injin vermin." The lands thus seized most W.A.S.P.ishly (*W*hite, *A*nglo-*S*axon, *P*rotestant) had to be cultivated. More tractable Negro slaves were imported from Africa. In spite of the Civil War and various constitutional amendments, the average American still has the lingering notion that the white man is *inately* superior. Most conveniently, this justifies continuing discrimination against the *un*educated black man.

The "whitey" reproach — the hunger for "black power" — the confused babble of protests in the cauldrons of the ghettos: these are forecasts of "hot summers." Hopefully, also, they are signaling the new articulateness of a "rising tide of expectations" that may be heralding the integration of the educated Negro and Puerto Rican into a society that has already accepted the Irish Catholic, the Polish Jew and the Near Eastern Mohammedan.

While all this may be in the immediate future, in our land eyebrows are still raised when an accepted white insists on black status! In all fairness, such an aberration may be labeled REVERSE RACISM.

Consanguineous Concatenation

Sabre La Guerre* could trace his ancestry back all the way to the Huguenots. Admiral Coligny and most of his followers were massacred on St. Bartholomew's Day in 1572. A few of the survivors managed to find their way to England, then ruled by Elizabeth I (the great Virgin Queen). These Huguenot nobles dropped the *de* in front of their names and became loyal subjects of the queen. A La Guerre was on the losing side of the English Civil War when Oliver Cromwell became Lord Protector of the Commonwealth. After Charles II ascended the throne, the La Guerres acquired generous land grants in the colonies. The "Bonnie Prince Charlie" fiasco drove them into permanent exile to the New World.

Life there flowed at a leisurely pace. The Creole planters had non-white concubines: many whites acquired Indian wives. Sabre spoke often of a La Guerre who had had an Arawak bride. (A fine portrait of the son of that union still decorates the entry hall of the mansion in which Sabre was born.) The succeeding generations of the La Guerres married within the milieu of their closely-knit Creole society. By all accepted criteria, Sabre was a white man: a Creole but NOT a Creole Negro.

A most crucial fact in Sabre's career was a curious, quite common, biological phenomenon: in appearance, he was a total throwback to that ancestor who was the son of the Indian, Arawak mother! Reversions to type have been known since time immemorial. Whatever the modern, genetic terminology: the fact remains that the continuing chromosomal re-shuffles frequently come up with an "old deal." The renowned Russian poet, Alexander Pushkin, had the unmistakable physiognomy of the Negro slave forefather who had been presented to Peter I. The famous Conan Doyle tale, "The Hound of the Baskervilles," revolves around the resemblance of the villain, Stapleton, to his Stuart progenitor. Hawk-eyed Sherlock Holmes spotted the similarity and thus was enabled to draw the clarifying conclusion.

Let us pass over the fact that Sabre would have been accepted in all places for what he really was: a British colonial born overseas. The exact nuances of the psychology of this proud man have continued to baffle me. Among his many reticences was the question of his true age. I suspect that he was born earlier than the date, 1875, that he always gave me. He was fond of recalling tales of the wild oats he sowed as a member of Oscar Wilde's avant-garde set in the London of 1890. Apparently, the wealthy, handsome aristocrat must have cut quite a swath, both with the highest society and the demimondaine. No matter how precocious, at the opening of the fin de siecle decade, he *must* have been older than the stated age of 15!

*All resemblance to persons living or dead is strictly coincidental.

The decadent nobility of a vanished era atoned for its many sins by breathtaking bravery in the blood bath of World War I. Sabre was one of the swagger-stick flicking officers who led their men over the top just too many times to count. The Somme, Dimy Ridge, Ypres, Verdun — he survived all the holocausts: "Not a scratch!"

Neuropathic Negrophile

After the Americans came in, he was detached to their newly arrived battalions. Now Sabre was too intelligent a man to confuse an Indian ancestor with a mythical Negro progenitor. Yet, he made a fetish of that very point even while waving away the obstacle with a snap of well manicured fingers! Because of his insistence on the African (?) in him, this colonial was an ideal military adviser to the Southern troops composed almost exclusively of Negroes.

As an aftermath of the Woodrow Wilson era, Sabre moved to New York City, sinking deep roots in that megalopolis. Still the perennial bachelor, he was one of those who interested Julius Rosenwald in Negro education. He became a noted writer and lecturer in Negro causes. Unlike such contemporaries as Will Rogers, he suppressed totally any association with the Indian in him. Only occasionally did he travel to the West Indies where his brother carried on the patronymic duties of a La Guerre.

When World War II materialized, in spite of his age, Sabre wangled a commission for himself as a liaison officer between the Americans and the British; who could have better credentials? We now progress to 1945 and West Germany: Hitler dead and the Nuremberg trials in preparation.

For the first time, we record the appearance of Ilse Insel. Born in 1926 into the Rhenish family of a minor government clerk, she was exactly the right age at the right time and place to have gone through the entire brainwashing experience of the Hitler Jugend. Her father had become a loyal Nazi functionary. Both her older brothers had fought in the war: one as an often promoted SS officer; the other, as a well decorated, front line fighter on the eastern front. Ilse's older sister had married a fanatical commander of a most infamous Einsitzgruppen. A Russian shell had killed him before the Ukrainian guerrillas could execute him ala Heydrich.

The Nazi collapse had left the Insels stranded and in a blue funk. They anticipated receiving the same treatment from their conquerors as the Teutonic "ubermenschmen" had meted out to the "sub-humans" they had so fleetingly subjugated. The Insels were delighted to have General La Guerre and his staff quartered in their lovely villa. This seemed to offer a powerful shield against the forces crumbling their world about them.

Gallant Gyneolatry

The 70-plus year old colonial nobleman made an enormous impression upon the teen-aged madchen. During the frantic war years, she had consorted — often most intimately — with the "Heil Hitler'ing" young men going off to the front. The courtly graces of a 19th century bon vivant: Well! That was a thrill totally new to her. As to *color:* but Sabre *looked* white and anyway, had not Hitler called the yellow Japanese "fellow Aryans"? Certainly, no one had ever treated her with the automatic deference — all the additive little courtesies that were the very warp and woof of Sabre's overpowering personality.

The tale is hardly prurient even if careful phrasing is needed. The skilled suborner had little difficulty in having Ilse come to his couch. In later years, she confided to me that, "He really taught me the meaning of sex: very different from those Hitler Jugend jerks." Ilse had a gay time traveling about as the general's secretary.

But: how in the world did she go about getting Sabre to MARRY her? As a personal friend and physician of their later years, I became privy to many of their inmost cogitations. Still, a reconstruction of their thought processes continues to elude me. Granted that Ilse was almost desperate to desert the shattered Teutonic idols that she had been reared to revere and that had proven themselves to be so fallibly false. She yearned to go to the New World and start afresh the kind of life so intoxicatingly exemplified by this Creole. But, Sabre??

Over the lengthening decades, he had had his pick of all strata of society. What was the electrifying elan vital of this teen sprig of a strumpet? Granted his REVERSE RACISM; making all allowances for his inexplicable blind spot re Indians and Negroes — surely, the confirmed bachelor did not need a marriage license to prove Creole Negro superiority over Aryan maidenhood. He still could go to the gym and box three rounds with excellent pros! His sexual prowess remained tres formidable. Yet, a decade later, I was to hear him, almost dreamily, say, "Ilse is so different." Hardly original; downright perplexing, considering the source. Why the sudden desire for permanent, legalized companionship? Could Freud or Pavlov describe the underlying motivations except with threadbare, hackneyed, trite phrases? Unfortunately they are not available for consultation.

Be all these ruminations as they may, General AND Madame Sabre La Guerre traveled to the West Indies where she was — most decorously — introduced to the family. In due time they proceeded to settle in a lovely eyrie atop a New York City co-op. The view of the Hudson was simply fabulous and downtown Manhattan was on the other side. And the years came and went.

Herculean Herniorrhaphy

One week-end, while rearranging the desk in his study, Sabre suffered a sudden, lancinating pain in his groin. The La Guerres had seen my name plate with the M.D. suffix; for lack of any one more convenient, I was called — and came. The man had an obvious, acutely incarcerated hernia. Cautious manipulation failed to budge it. For the first time in his 80 (or was it

more?) years, Sabre was hospitalized. Within the hour, a renowned surgeon was making an incision on our friend.

The usually simple operation turned out to be a toughie, indeed. It seemed that Sabre had had for many years a symptomless, partial, sliding (Richter) hernia. The final strenuous effort had rammed some small intestine into the cul-de-sac. My skilled surgical colleague toiled for over two hours before he was able to disentangle the conglomerated mess. As an incidental feature, the femoral vessels had also been subjected to compression. It was a relief to see pulsations in them as well as the popliteals. Postoperatively, the surgeon and I visited Sabre rather more often than usual. The unexpected difficulties in an aged patient had made us more apprehensive than the actual events were to prove themselves.

Throughout, Ilse was very much in evidence: an adornment to any landscape. Also, the juxtaposition of the youthful, blue-eyed, abundantly blonde tressed, bouncingly bosomed Valkyrie with the very elderly even if ever so well preserved, distinguished British colonial as WIFE and HUSBAND: this was neck-craning to say the least. Ilse was well aware of the gossip behind her back. During our very first encounter, she took the time to smile disingenuously and make the gambit, "My husband has had many mistresses but I'm his *first* wife."

Sabre La Guerre had a flawless postoperative convalescence: nary a complication. When it came time for him to pay my bill, he looked at the statement, flicked the air with the grace of a ci-devant nobleman of the Huguenot era and observed, "Oh, doctor. This is not nearly enough; my finances can stand much more." He wrote forthwith a check for twice the requested amount. I've had such experiences before and since but never carried off with quite such an insouciant air. . . .

This episode was the beginning of a most different, neighbor cum doctor relationship. Years were to pass before I realized that Sabre La Guerre claimed to be a militant Creole *Negro*. It happened that, one day, he gave me an inscribed copy of a monograph of his on the position of the Negro in American history. This permitted me to ask without undue prying: I began to absorb many of the subtler nuances of what made the La Guerre menage function. To my knowledge, Sabre was always the doting husband. However, in Ilse I could watch, over the succeeding years, the slow change from a mere toleration of her spouse to a respect, admiration and — shall I say — a genuine love.

One day, she came to the office unheralded and alone. "I want an exam — complete." The usual routine did not quite satisfy her. She blurted out her need. "Sabre is with me: often; oh, yes. He is still plenty virile, indeed. Why do I not get pregnant?" "No! before you send me to a gynecologist, please, do a careful internal examination."

I checked the impulse to repeat the hoary joke anent the internist and an internal examination. The nurse prepped Ilse well; I took ample time to examine her carefully. The tubes did have that suggestion of a pipe-stem feel. (See The Case of the Sterile Siren, *JISMA* 54:200, 1961). It could also have been the old g.c. to which she confessed most candidly. Still, the tuberculin test was very positive; the Ghon tubercle was amply evident and there were the old, well-healed apical scars in the tops of both lungs. . . . All that the gyny man could do was to confirm the fact of the sealed Fallopian tubes. The question of surgery came up: nothing further was done.

Impuissant Inamorato

More years came and went. Then there was an unexpected, middle of the night, long distance call. It was Ilse talking from the La Concha Hotel in San Juan, Puerto Rico. "Doctor; Sabre is terribly ill. We had gone to the Yunque forest this morning. We got back horribly pooped. Instead of crawling into bed, my gay blade insisted on getting into formal attire and going to a stupid charity ball here in town. He danced me into the ground. We got to our room awfully late. He started to undress, dropped a cuff link and asked me to look for it. Then, he gave me a funny look and just slumped to the floor.

"I called the house doctor immediately. He said that Sabre had had a stroke: CVA, he called it. I don't want him in a hospital here. I've already called the airport: the ambulance is on its way. YOU take over from there. Please, don't argue with me."

The click of her hanging up deterred any arguments on my part. The miracle of the modern jet permitted my greeting the La Guerres at my hospital not too many hours later; it was still midmorning. The anesthesiologist, the x-ray people and all the necessary personnel had been alerted and were ready. While my most trusted neurosurgical colleague was out of town, his excellent associate was there.

A rapid but careful examination revealed the fact of the completing left hemiplegia. A spinal tap yielded crystal clear fluid with all parameters being within normal limits. An angiogram was performed stat (Figure 1). The occlusion of the right middle cerebral artery at the trifurcation was unmistakable. We toyed with the idea of keeping the catheter in situ and injecting directly such fibrinolytic agents as urokinase or epsilon caproic acid. We also considered — albeit only briefly — the feasibility of craniotomy and direct extraction of the precisely localized, 12 hour old clot.*

However, Sabre's general condition

*The whole subject of correct therapy for stroke (cerebrovascular accident) is undergoing constant revision. See: Clinicopathological Conference, *JISMA* 55:1510-1515, Oct., 1962; Intermittent Cerebral Insufficiency, A. Lieberman, *Geriatrics* 20:213-218, March, 1965, and "Cerebral Angiography," *JAMA*, Sept., 1966, p. 803.

FIGURE 1
ANGIOGRAM shows the occlusion of the right middle cerebral artery at the trifurcation.

was deteriorating too rapidly to permit any thought of further manipulations — no matter how desirable on theoretical grounds. Since the hernia repair of several years back, he had steadfastly refused medical check-ups. But it was already obvious that this was *not* the same patient whose magnificent physique had been such a source of amazed gratification. Of course, due allowances had to be made for the long trek by ambulances and plane, the spinal tap, the arterial catheterization — all coming after the physical exertions preceding the CVA that would have taxed to the limit a man in the very prime of life.

We settled for sympathetic cervical spine blocks even while we started in all haste the urgent treatment of impending shock. Sabre got the works: devoted around the clock nursing care plus the carefully monitored therapy using all medical, physical and what have you modalities — mostly, the standard and well accepted: also, some still experimental even if, hopefully, promising. The hemiplegia was complete; in his lucid intervals, speech was slightly slurred but intelligible. He loathed the Foley catheter, the Levin tube and oxygen tent; that was understandable even if unavoidable. But — why the repeated bouts of congestive heart failure?** Of bubbling pulmonary edema? Of ileus? And those horrible decubital sloughs . . . and on what grounds was the roentgenologist making a mumble auent "pulmonary emboli??"

Sabre went on a veritable binge of assorted cardiovascular and pulmonary oscillations. The objective criteria of myocardial necrosis were never present. The countless E.K.G.'s, the enzyme levels, the blood counts — all the innumerable tests were never on the affirmative. His hands were warm, the pulse was bounding and there was an apical third sound. There was also a short diastolic rumble and an ejection systolic murmur in the pulmonic area. The frightening pulmonary edema came and went: the circulation time was only 11 sec.. The liver was only moderately enlarged and failed to give us a clue for the precariously poised, high output failure state.

Decrepitudinous Don Juan

The several years that had elapsed from his marvelous recovery following the hernia surgery could not really account for the totally different patient we now had. Of course, by now, Sabre was most definitely a nonagenarian no matter what year we assumed to have been the date of his birth. Still, what in blazes had produced so dreadful a deterioration from the ageless lover of the recent past to the present dismayingly deteriorated, senile dotard? Surely not the carotid artery occlusion.

While discussing the situation with an eminent consultant, we were almost driven to the thought that: *amyloidosis* was as good a diagnosis as any — to be verified subsequent to the event as we did not have the courage to do a cardiac biopsy. But — why such a rapid onset? Also, what was the roentgenologist saying about "pulmonary shadows consistent with cardiac disease . . . pulmonary emboli not excluded?" There was nothing in the legs even remotely suggestive of phlebothrombosis (or phlebitis); the abdomen was barren of clues: the old

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**So much has been written about congestive heart failure that, now and then, even experts almost lose sight of the forest for the trees. Basically, we should recall that with the failing circulation — backward or forward — the tissues become deprived of O_2 and the irreducible number of calories essential to their needs. The heart fails when the myocardium fails. This includes ALL heart disease and is far beyond the scope of a footnote. (See: Luisada, Price, Cecil-Loeb, Friedberg, etc.).

Backward failure was first mentioned by Corvisart, Napoleon's physician. Many subsequent leading clinicians made this the accepted, standard explanation. Starling's laboratory studies with the acute heart-lung preparation gave this a rational, physiological basis. Certainly, it seemed to explain the back pressure with the familiar hepatojugular reflex, the rising venous pressure, the dependent edema and the concomitant signs learned by every medical neophyte.

However, Starling's acute experiments could not take into account some chronically developing states. He had no facilities for the study of the immensely elaborate vagovagal CNS (central nervous system) reflexes. He did not deal with chronic cardiac dilatation and hypertrophy. And, how about the fall in renal output being selectively greater than the fall in cardiac ejection per beat? In passing, let us only mention the vast complexities of selective membrane permeability — the specific role of various ions, etc., etc.

Forward failure is accompanied initially by sub-normal venous pressure and shortened circulation time (a frequently forgotten, simplest of simple tests). The inadequate blood supply to the tissues may be due to the exorbitantly rising demands or a failing myocardium just becoming progressively more inadequate. In shock, the killer is lessening cardiac output with precipitous fall in blood pressure. Less horrifyingly acute but never to be forgotten (except at the peril of missing the right diagnosis and thus the appropriate therapy) are such conditions as 1) various endocrinopathies, especially thyreotoxicosis 2) vitamin deficiencies, such as beri-beri, etc. 3) amyloidosis — the primary form in the elderly male can be most misleading — 4) A-V fistulas of whatever variety, etc., etc.

However, today, in an attempt at an Hegelian synthesis, there is the beginning of a consensus. Admitting our still existing vast areas of ignorance on many basic factors, we strive to spell out the sequence of events in each instance without stressing mere dogmatic assertions. We scrutinize the failing homeostatic mechanisms and try to correct them without being overly insistent on a precise nomenclature.

hernial scar was well healed and absolutely non-tender. True, the urologist was raising his voice. "That constant indwelling catheter is raising hob with the poor guy's water works. Also, I just don't dig the feel of the prostate; when will you pill-pushers let an honest surgeon insert a cystoscope with a planer? That biopsy could very well prove the presence of a malignancy."

Let us digress from the dismal medical recitatif. There was Ilse! I was baffled, astounded and genuinely deeply moved by her unobtrusive, quiet display of the profoundest love for her critically ill husband. No matter how spotless the linen — Sabre lying there was less than handsome. And yet! So gentle was Ilse's hand grasping his! So wistful was her encouraging smile! And, when he began to have lucid intervals, so evident was Sabre's affectionate reciprocity! To hold her hand was bliss that made more tenacious his resolve for a firmer grip on life! Privy as I was to their stories, comprehension of the mutual magnetism continued to elude me. What was the bridge spanning the half century plus gap between them? My medical, psychiatric and plain literary reading has nothing to aid my gropings. I was non-plussed: to my limited understanding, this was just about a new phenomenon under the sun!

As the days lengthened into weeks, the patient's bizarrerie of complications seemed to enter a decrescendo course. The hypostatic pneumonic bouts (maybe, infarcts: from where?), the recurrences of the cardiac failure — all the anxious episodes became interspersed with lengthening rallies in which there was mental clarity and good speech! The spells of profound lethargy were not as deep. The reproaching, sloughing decubiti still plagued the nurses!

So, miraculously — contrary to all the assembled expert opinions — finally, Sabre began to mend: ever so slowly but indubitably on the upgrade! I told hovering Ilse that she was a better tonic for Sabre than all our medicines. It was heart warming to see a maidenly blush of pleasure mantle her cheeks! With the gradual betterment, our patient had begun sitting up on the chaise lounge. He was eating well; the water works were doing so well that the Foley catheter could be removed. He was talking reasonably well: there was a whole week without the recurrence of the harrowing, bubbling rhonchi of pulmonary edema. Of the team of specials, only the day nurse remained on duty. We were in the process of reducing medications; the physiatrist had evaluated the patient's hemiplegia; he had been moderately optimistic and outlined plans for starting passive and active exercises that very week.

Post-mortem Perambulation

Then — on the very day I had planned to remove Sabre from the critical list — the entire edifice collapsed! The patient had been lifted to the chaise lounge by the nurse who then left the room on some errand or other. Only Ilse was sitting on a chair snuggled against her lover. The pair were holding hands and making gay plans anent this and that. As Ilse described it, very suddenly, he gave her a "funny look — sort of a stare, as he had done in Puerto Rico." Then, his head "lolled back, he gasped — and stopped breathing!"

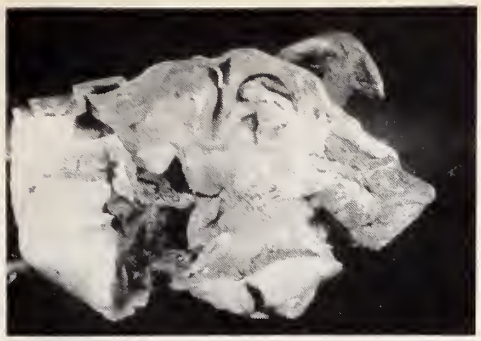
In prompt response to her anguished screams, everybody on the floor came a-running. Sabre received forced external cardiac massage, cardioverter, intermittent positive pressure via the Bennett respirator, stimulants intracardially: the works and then some. I was the late arrival within the half hour. Our dedicated efforts were to no avail whatever. Completely baffled, I insisted on an autopsy. "Whether Sabre had a massive myocardial infarct or a pulmonary embolism or just what — we had all striven mightily and we ALL were entitled to learn as to just what had happened! We are *not* going to bury our mistakes. You, Ilse, MUST give the permit."

Still sobbing almost uncontrollably, Ilse signed. "It's hard but you know best; please, don't mutilate — the body!" She had paused and shuddered at that last, softly whispered word. Within another two hours, the pathologists were at their task. I'm looking at the voluminous report now. Some quotes are to the point. "The body is of a well developed, well nourished male appearing considerably younger than the stated age of 91 . . . ."

Further on, "The brain weighs 1250 grams . . . No gross occlusions of the Circle of Willis are evident . . . Complete dissection of the cerebral arteries shows that, at the point of the bifurcation of the right middle cerebral and the right anterior communicating arteries there is a yellow-red, friable thrombus occluding most of the lumina of these arteries." This we knew from the original arteriogram. It was grim consolation to know that some re-canalization had already occurred. Complete resorption could have been expected even if there was a well demarcated infarction of most of the caudate nucleus and possible necrosis of the adjacent internal capsule.

" . . . The heart weighed 530 grams and was diffusely enlarged . . . The myocardium is yellow-brown and somewhat *waxy*. When stained with iodine, it assumed a mottled, brown-black color. There are no gross areas of fibrosis. The coronary arteries arise by ample ostia and . . . have no areas of occlusion." Microscopically, "The myocardium is diffusely infiltrated by amorphous eosinophilic material which is present within the muscle bundles, displacing and surrounding them . . . The amyloid stain was strongly confirmatory" (Figures 2A and B). In other words, as suspected, primary amyloidosis was proven to have been the cause of many of the clinical gyrations we had seen. The chief pathologist was emphatic in his positive assertion that this was the severest case of its kind that he had ever seen. The amyloid extended along the sheaths of many peripheral blood vessels coating them with its characteristic material.

The prostate confirmed the fears of



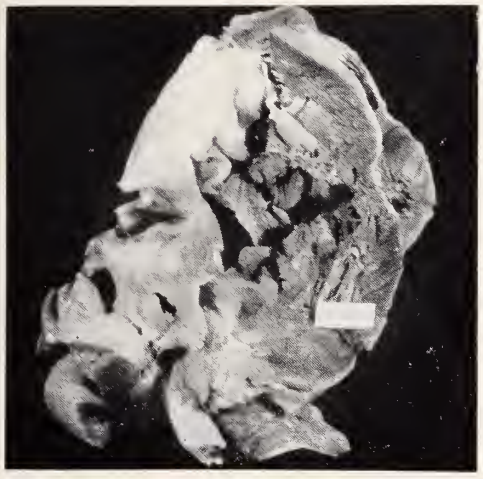


FIGURE 2A and B

THE myocardium at autopsy was diffusely infiltrated by amorphous eosinophilic material, proving the primary amyloidosis.

the urologist: squamous metaplasia was present and there were neoplastic changes. Furthermore, "the prostatic urethra is ulcerated and the bladder epithelium exhibited a cover of a dense, fibrino-purulent exudate . . . ." It was doubted that these changes accounted for the infiltrative alterations uncovered in the *left* pelvis. If the right-sided hernia surgery was to create a locus minoriae resistentiae, the changes should have been on the same side. Anyhow, there were massive, ante-mortem, friable thrombi partially occluding the LEFT external iliac artery and its continuation as the left femoral artery!! Totally unsuspected clinically — missed by yours truly and the cluster of coruscating consultants! Added proof (if any is ever needed) of the value of post-mortem studies. Certainly, a very prime reason for Sabre's dramatically sudden death.

Now you will not be surprised to hear that, "the right lung weighs 850 gm. and is inelastic . . . The right pulmonary artery is occluded by large, brick-red, loosely adherent emboli . . . The left lung weighs 780 gm.; it is billowy and inelastic . . . The artery to the lower lobe is completely occluded by similar emboli!" The lungs had been showered by repeated bursts of pulmonary emboli. The final massive, nigh total occlusion of the pulmonary arteries abruptly terminated the clinical tale.

Retrorse Ruminations

The *New York Times* headed the obit page with a two column spread detailing the distinguished career of the decedent. His services in both world wars, his books, his charitable deeds, his lectures on the Chatauqua circuits. . . . The final paragraph was succinct, "surviving him is Mrs. La Guerre. There are no children. Funeral services will be strictly private. It is requested that, in lieu of flowers, a donation be made to the donor's favorite charity."

The body was flown to the La Guerre ancestral estate; burial was in the La Guerre private cemetery just outside the chapel built more than 300 years ago by the original Huguenot land patentee. I had been asked to go along, it was both an honor and an opportunity to see at first hand the scene of so many events described to me. Particularly instructive was the contemplation of that long deceased ancestor whom Sabre was supposed to resemble so strongly. Indeed, one could hardly tell them apart! Over the centuries, that Arawak son had reached out to mould Sabre's life.

I stayed only a few days; Ilse stayed to go about the business of getting her husband's estate settled. On the plane homeward bound, I had some questions to ponder. How come that the pelvic thromboses had produced no incriminating signs either before or during Sabre's final illness? Would plication or ligation of the inferior vena cava have minimized the embolic bombardment of the lungs? How long had he had the primary cardiac amyloidosis? We had attributed the pulmonary picture to the assumed (and later abundantly proven) presence of the primary amyloidosis. What substantial additional role was played by the thrombi being dislodged from the iliac and femoral veins? And the burgeoning malignancy? Ultimately, was it not better for Sabre himself that the end came the way it did? That dignity in death sermon!?

These reflections always reverted to the ties that riveted together the incongruous pair in such intimate fashion. Latest December and earliest spring were certainly exemplified by this duly wedded couple. I know nothing in all literature that probes just this question. My feeble prose only mirrors my bewilderment; just what were the drives of these so totally disparate man and woman?

One final item! Just recently, Ilse came in to see me professionally. The day before, she had returned from the Caribbean. Her flaring urethritis smeared out G. Neisseriae in abundance! Bluntly, I told her the truth. Her reaction was one of shocked indignation.

"That Armand La Guerre! Yes, he's the grandson of Sabre's younger brother. The jerk has been courting me all the time I was down there; he's a bit younger than I and still a bachelor. He *looks* a mite like Sabre; I let him get into my bed just two days before my departure for New York. I *thought* I might recapture some of Sabre's magic but: what a disappointment! Most selfish and vulgar jackass I ever did see! And now — this. I'll tan his hide for lamp shades!"

"Well, Ilse! Your maiden name was Insel and not Koch! The infection is easily cured nowadays; your sealed off tubes will guarantee against an internal spread. I will give you enough penicillin to make sure that no syphilis will develop later. That has been a major weakness in our anti-venereal disease campaign."

The sputtering widow was not calmed easily. Also, I'm left with an anti-climax for my Romeo and Juliet (or Abelard and Heloise; Dante and

Beatrice: Frankie and Mia or what have you story). Regardless of the puerile closing whimper of the love saga of Sabre and Ilse — the story begged to be narrated even if the teller is less than professional. We all regret that neither Chekhov nor Maugham are with us to lend their incisive stamp. Properly told, it could have been a best selling classic! ◄

1270 Fifth Ave.
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ASTHMA: IMMUNOLOGICAL AND NON-IMMUNOLOGICAL

One of a series of case reports illustrating the differential diagnosis in patients with symptoms of asthma

IRVIN CAPLIN, M.D.
JOHN T. HAYNES, M.D.
Indianapolis

A 55-year-old woman had been under treatment for asthma for the preceding six years. She had had asthma for 18 years and for the prior three years, it had been necessary to keep her on cortisone continually to control her symptoms. She developed pain in the left clavicle which was quite sharp and lancinating; she had no asthma with this.

Physical examination revealed tubular breathing throughout the left lung field with some dullness. A chest x-ray (Figure 1A) revealed what was felt to be a hilar infiltration, probably due to tumor, although tuberculosis and pneumonia were also considered. Because of a sensitivity to iodine, bronchograms were not done. A bronchoscopy was negative. A thoracotomy was contemplated to make a definitive diagnosis.

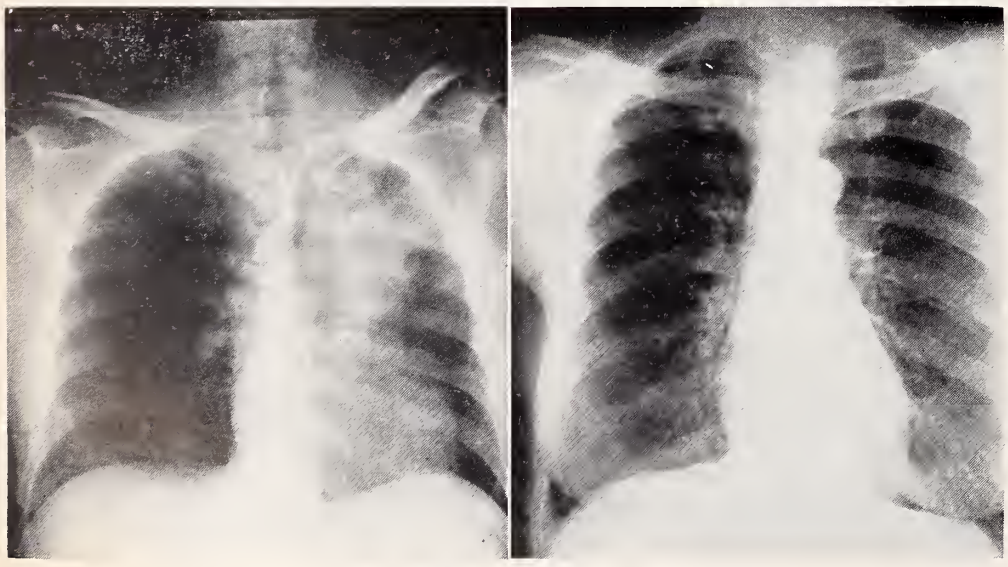

FIGURE 1A and B

ATELECTASIS of the left lung (1A) was felt to be produced by a large carcinoma. Two weeks later (1B) there was complete clearing of the left lung field.

However, 48 hours prior to her planned surgery, the patient had a severe paroxysm of coughing and coughed up a large mucous plug. A re-x-ray of her chest (Figure 1B) revealed the lung to be re-expanded and no evidence of pathology remained. It is felt that this represents a patient who had a large mucous plug, and subsequent atelectasis, which simulated an inoperable carcinoma of the lung. ◄

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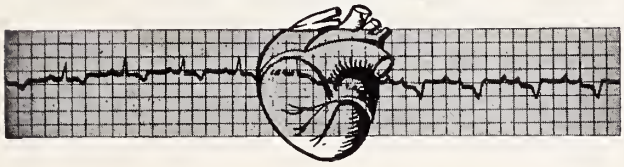
Electrocardiogram of the month



Presented as a regular feature of The JOURNAL, Electrocardiogram of the Month is a series of short talks on cardiovascular diagnosis and treatment, edited by the staff of the Krannert Heart Research Institute, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis.

Cardioversion in Presence of Digitalis Toxicity

CHARLES FISCH, M.D.
Indianapolis

CARDIOVERSION is as a rule contraindicated in arrhythmias due to digitalis because it frequently fails to terminate the arrhythmia and, on occasions, is followed by a more severe disturbance of rhythm. In addition it has been repeatedly demonstrated that cardioversion may unmask digitalis toxicity. Such an event is shown in Figure 1.

The control strip demonstrates complete heart block in a patient who received an unknown amount of digitalis. Spontaneous ventricular tachycardia appeared (row 2) and was terminated by cardioversion. This procedure resulted in unmasking digitalis toxicity (row 3) in the form of a paroxysmal atrial tachycardia with a rate of approximately 140. There is no temporal relationship between the P and QRS complexes. The latter have a rate of approximately 90 as against a control of 36 and a grossly aberrant QRS indicating the persistence of a ventricular tachycardia.

Resumption of complete heart block with repetitive runs of ventricular tachycardia is seen in the fourth row. The arrhythmia was finally controlled with an intracardiac jugular pacemaker. ◄

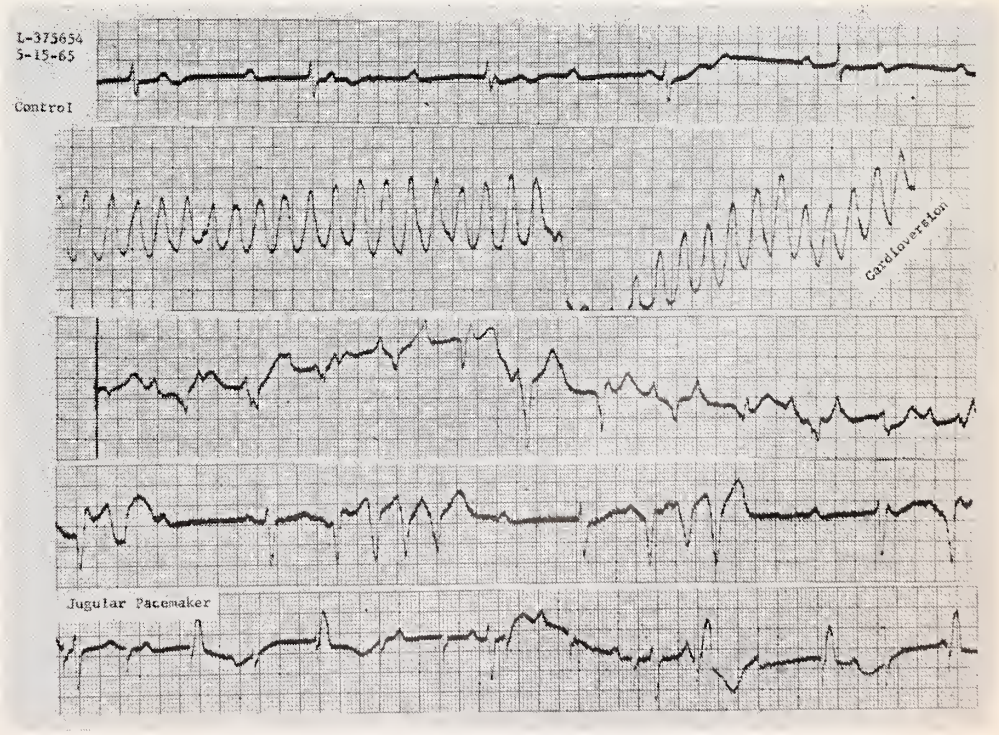
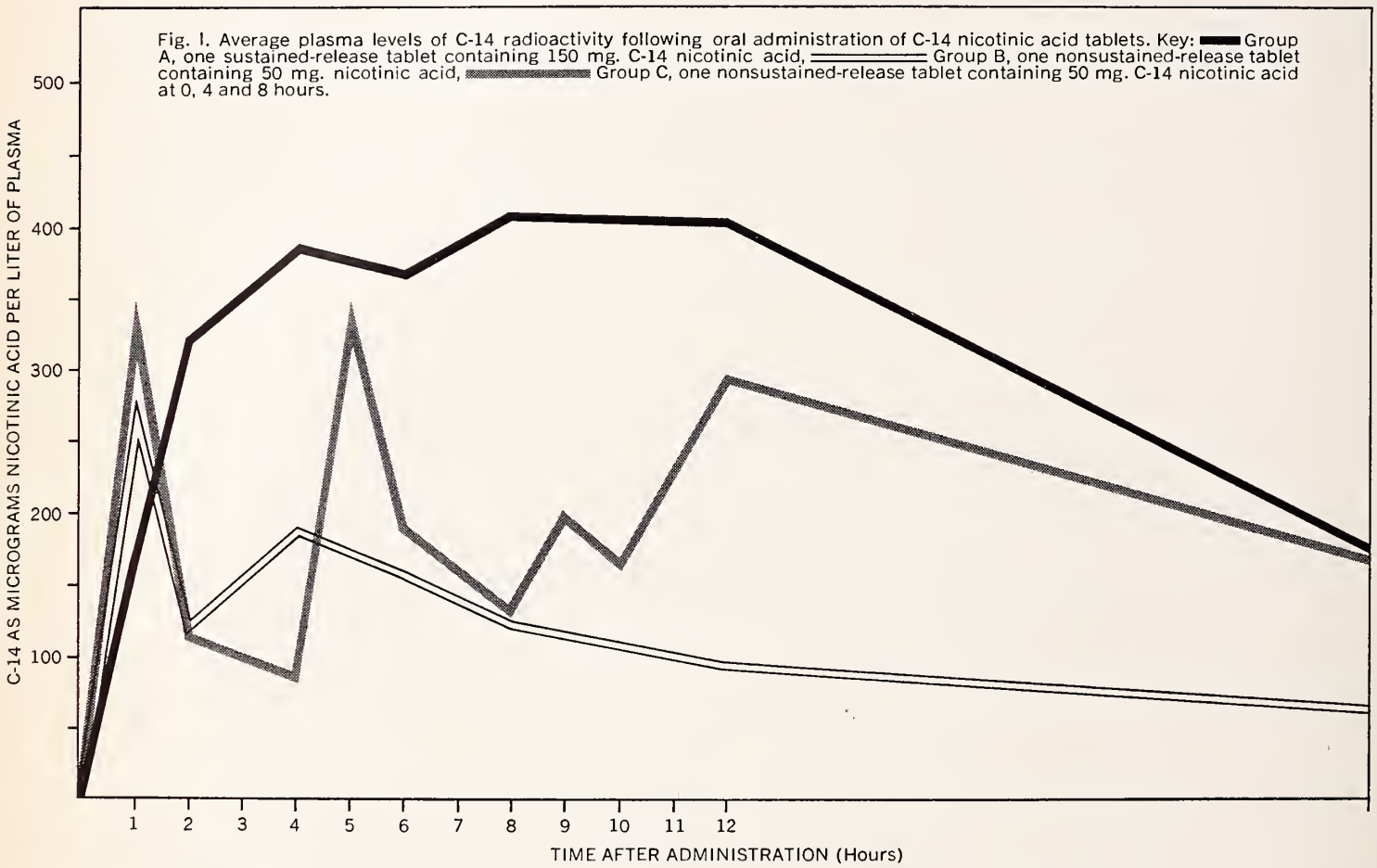


FIGURE 1
CARDIOVERSION and an intracardiac jugular pacemaker were used to control the severe disturbances of rhythm in a case of digitalis toxicity.

Sustained circulatory, respiratory and cerebral stimulation for the



(fewer absent doses by absent-minded patients)

Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be continuous on a daily dose of only one Geroniazol TT tablet every 12 hours.

The gradual release of nicotinic acid in Geroniazol TT will provide the well-known peripheral vasodilatation needed in patients with deficient circulation and with a minimum amount (if any) of "flushing." Also, cerebrovascular circulation is complemented by pentylenetetrazol, long-established as a cerebral and respiratory stimulant.

Geroniazol TT improves the typical, unfortunate, signs of senile confusion. Patients become more alert,

aged and debilitated

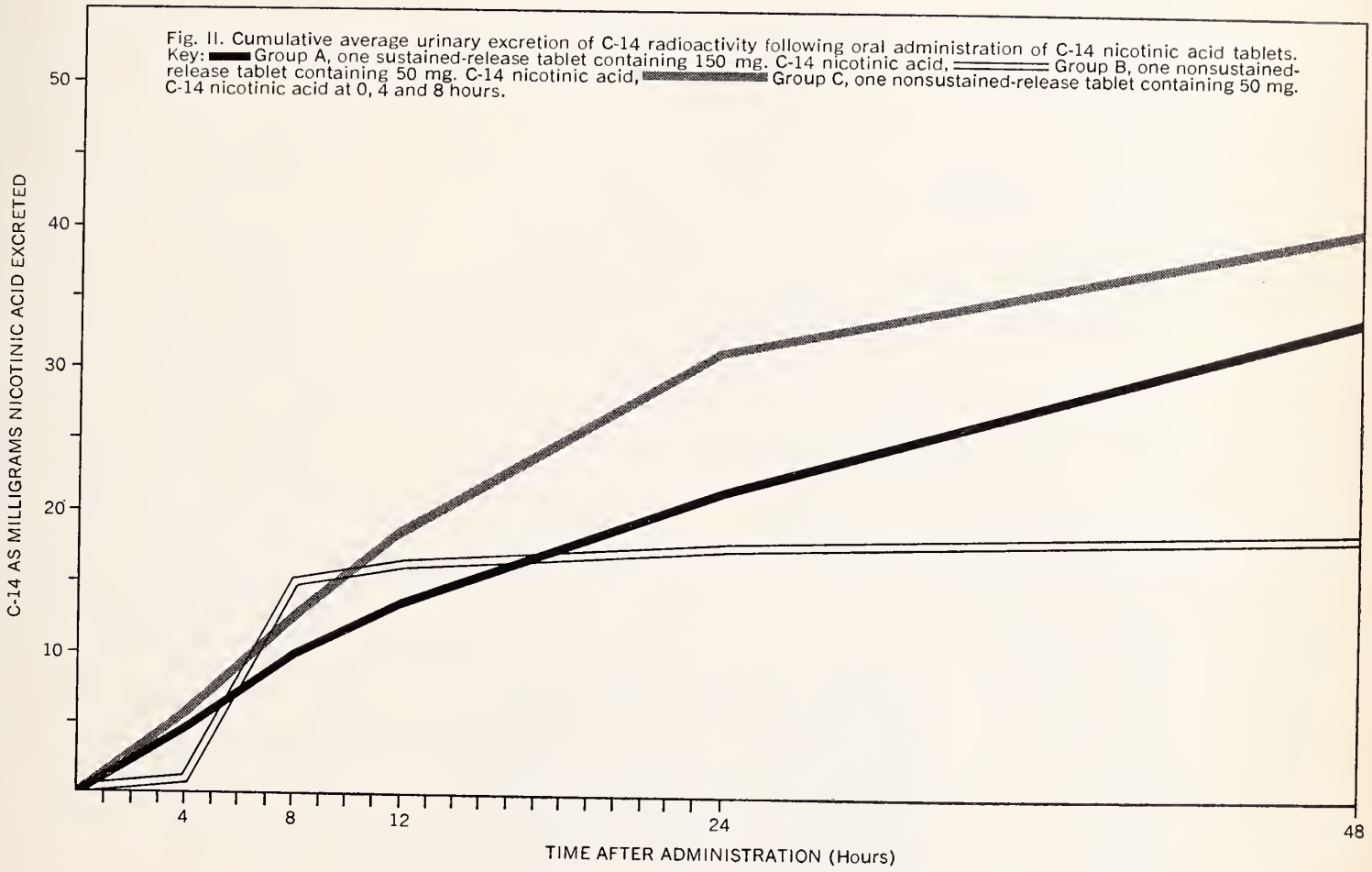


Fig. II. Cumulative average urinary excretion of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, Group B, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid, Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

less confused and moody. Personal care, memory, emotional stability, social attention improve. Fatigue, apathy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will permit your patients to enjoy the benefits of time-prolonged nicotinic acid/pentylenetetrazol therapy, at an economical price. Dosage is only one tablet every 12 hours.

Contraindications: There are no known contraindications.

Precautions: Exercise caution when treating patients with a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

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X-RAY CONFERENCE

Presented as a regular feature of *The Journal*, X-ray Conference is a series of short talks on procedure and radiologic diagnosis, edited by Erich K. Lang, M.D.

Arteriovenous Malformation of the Occipital Region

ERICH K. LANG, M.D. *
JOHN A. HETHERINGTON, M.D. †
Indianapolis

A 48-year-old white female was admitted to the hospital with complaints of severe occipital headaches and a noise sensation in the occipital area. A carotid arteriogram revealed an arteriovenous malformation supplied by the occipital branch of the external carotid artery.

The left external carotid artery was ligated and the patient recorded immediate cessation of all symptoms. However, only three months later, the symptoms gradually reappeared and at the time of readmission, a constant "droning noise" had developed.

A selective catheter arteriogram of the left common carotid artery revealed a satisfactory ligation of the external carotid artery. There was no evidence of refilling of the arteriovenous malformation.

A selective injection of the left subclavian artery showed a large, apparently hypertrophied, left vertebral artery (Figure 1). The ascending cervical artery was likewise hypertrophied. and appeared to fill the arteriovenous malformation.

FIGURE 1

NOTE the dilated and hypertrophied vertebral artery. The ascending cervical artery, originating from the thyrocervical trunk is also unusually large, and supplies the arteriovenous malformation in the occipital area.

Discussion

Arteriovenous malformations in the occipital region are commonly supplied by multiple feeder vessels. The occipital branch of the external carotid artery, the foramen magnum branch of the vertebral artery and the occipital branches from the ascending cervical artery are the most common suppliers. Frequently, the malformation is predominantly filled by one vascular system. However, after ligation of this major supply, the secondary supply route will take over, hypertrophy, and symptoms tend to reoccur. Repeated ligation of the arterial supply may, therefore, become necessary. In many instances, a three-stage procedure is contemplated for a successful ligation of all feeder vessels of an arteriovenous malformation; thus allowing interim development and dilation of the secondary collateral systems to facilitate subsequent surgical ligation. Embolization with foreign particles has been attempted in these areas, but has not been satisfactory. ◄

*Radiologist, Methodist Hospital, Indianapolis.

†1633 N. Capitol Ave., Indianapolis.

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Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are:

Children: Total Daily Dosage

3-6 mo. . . ½ tsp.* t.i.d. (3 mg.)
6-12 mo. . ½ tsp. q.i.d. (4 mg.)
1-2 yr. . . . ½ tsp. 5 times daily (5 mg.)
2-5 yr. . . . 1 tsp. t.i.d. (6 mg.)
5-8 yr. . . . 1 tsp. q.i.d. (8 mg.)
8-12 yr. . . 1 tsp. 5 times daily (10 mg.)

Adults: 2 tsp. 5 times daily (20 mg.)
(or 2 tablets q.i.d.)

*Based on 4 cc. per teaspoonful.

Maintenance dosage may be as low as one-fourth the initial daily dosage.

Precautions: Lomotil, brand of diphenoxylate hydrochloride with atropine sulfate, is a Federally exempt narcotic preparation of very low addictive potential. Lomotil should be kept out of reach of children since accidental overdosage may cause severe respiratory depression. Recommended dosages should not be exceeded. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates. The subtherapeutic amount of atropine is added to discourage deliberate overdosage.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness, insomnia, numbness of extremities, headache, blurring of vision, swelling of the gums, euphoria, depression and general malaise.

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PHARMACOLOGY: Triaminic decongests and promotes drainage of nasal and paranasal passages, and prevents any further histamine-induced damage; the triple sulfonamides inhibit susceptible bacterial invaders. INDICATIONS: For congestion and infection of the upper respiratory tract caused by sulfa-susceptible organisms. DOSAGE: Adults: 2 to 4 tablets initially, followed by 2 tablets every 6 hours. Medication should be continued until patient has been afebrile for 3 days. ADVANTAGES: The advantages of Trisulfaminic in upper respiratory infections are: freedom from narcotics or alcohol; therapeutic reliability; safety; economy; ease of administration; freedom from potential sensitization to broad-spectrum antibiotics which may be reserved for lower respiratory or other infections caused by susceptible organisms. CONTRAINDICATIONS: Contraindicated in sulfonamide and antihistamine sensitivity, impaired renal function, pregnancy approaching term, and in premature infants and newborn infants during the first month of life. Do not use in patients with glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal or bladder neck obstruction. WARNING: Use only after careful evaluation in patients with liver or renal damage, urinary obstruction, or blood dyscrasias. Deaths have been reported from hypersensitivity reactions with administration of sulfonamides. In intermittent or prolonged therapy, blood counts and liver and kidney function tests should be performed periodically. Sulfonamide therapy may potentiate the hypoglycemic action of sulfonylureas. PRECAUTIONS: Use with caution in patients with histories of significant allergy or asthma. Assure an adequate fluid intake. Because the antihistamines may cause drowsiness of varying degree, warn patients about activities requiring alertness such as driving a car or operating dangerous machinery. Use with caution in the presence of hypertension, hyperthyroidism, cardiovascular disease and diabetes. ADVERSE REACTIONS: As in all sulfonamide therapy, the following reactions may occur: headache, nausea, vomiting, diarrhea, icterus, hepatitis, pancreatitis, urticaria, rash, fever, cyanosis, hematuria, crystalluria, proteinuria, blood dyscrasias, petechiae, purpura, neuropathy and injection of the conjunctiva and sclera. If one or more of these reactions occur, the drug should be discontinued. With antihistaminic therapy there have been reports of sedation varying from mild drowsiness to deep sleep, dizziness, lassitude, inability to concentrate, fatigue, incoordination, tinnitus, blurred vision, diplopia, euphoria, nervousness, insomnia, tremors, palpitation, hypotension, headache, chest tightness, urinary frequency, dysuria, tingling of the hands, dryness of the mouth, throat, and nose, gastrointestinal disturbances such as epigastric distress, anorexia, nausea, vomiting, constipation and diarrhea and very rarely, leukopenia and agranulocytosis. Adverse reactions reported with the use of sympathomimetic amines include anxiety, tension, restlessness, nervousness, tremor, weakness, insomnia, headache, palpitation, tachycardia, angina, elevation of blood pressure, sweating, mydriasis, anorexia, nausea, vomiting, dizziness, constipation, and dysuria due to vesicle sphincter spasm. PACKAGE INFORMATION: Trisulfaminic Tablets: Supplied in bottles of 100 tablets. CAUTION: Federal law prohibits dispensing without prescription.

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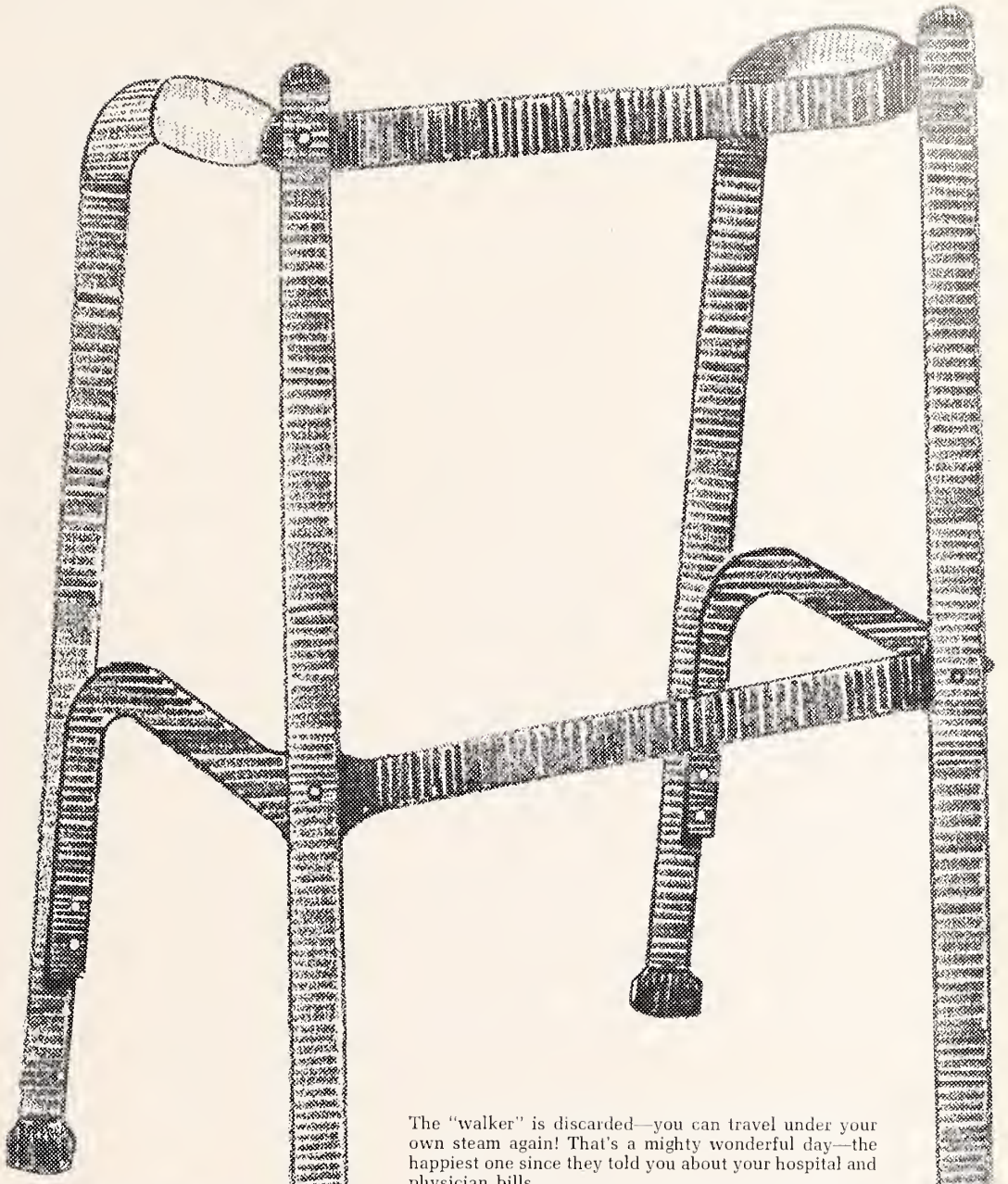

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Diabetes Week

THIS is Diabetes Month, and the week from the 13th to the 19th is Diabetes Week. Every year is Diabetes Year.

There are at least two million known diabetic patients in the United States. It is estimated that there are that many more unknown diabetics and some estimates are even higher. Diabetes is the eighth cause of death and the third cause of blindness.

Diabetes can be detected long before it is symptomatic. Early recognition and careful treatment pays dividends out of all proportion to the cost of discovery.

Diabetes Detection Week emphasizes the testing for glycosuria and in the case of all positive reactors, the investigation by other means to determine the presence or absence of the disease. The recipient of each "Dreypak" testing strip is asked to indicate on the strip the name of his or her doctor. Negative results are reported to the patient only, positive results to the patient and the doctor.

Actually every day should be Diabetes Day with every practicing doctor. Negative urine specimens and normal fasting blood sugars are common in early nonsymptomatic diabetes. The best screening test is a blood sugar determination two hours after a high carbohydrate meal. This is the best single test for seeking out early or potential cases.

In addition to the widespread annual testing of large groups of people with the "Dreypak" test, a constant search should be made day after day among those who have a likelihood of developing the disease. All blood relatives of diabetics, mothers of babies weighing over nine pounds at birth, the obese, and persons over 40 years old should be thoroughly investigated at regular intervals.

Joslin simplified and pinpointed the problem when he said "The unknown diabetic is not a mysterious person, he is the overweight relative of a known diabetic."

Special care should be taken in pregnancy. Often a woman will demonstrate her latent or potential diabetes only during pregnancy. Because of the serious complications of pregnancy and diabetes, a full diagnostic study is indicated in the early stages of every pregnancy.

Medical societies and chapters of the American Diabetes Association welcome the cooperation of industrial groups, schools, churches, and all public spirited citizens in observance of the annual Diabetes Week.

Trends in Personal Health Spending

PRIVATE expenditures for personal health services more than doubled between 1953 and 1963 — from $10.2 billion to $20.7 billion — but when this is calculated as a percentage of family income, the increase is only from 4.6% to 5.5%.

The Health Information Foundation conducted a family medical care expenditure survey in 1952-53, again in 1957-58 and most recently in 1963. Two thousand, three hundred and sixty-seven families comprising 7,803 individuals were selected to represent a cross section of the U. S. population, and were interviewed in depth.

The total expenditures in the in-between year, 1958, were $16.2 billion. The increase, therefore, from 1953 to 1958 amounted to 59%; from 1958 to 1963, it was only 28%. The 1958 figure represented 5.6% of family income. It is apparent that the five years from 1958 to 1963 were more stable with a much smaller rise in absolute expenditures and a slightly lower percentage of income.

The proportion of each dollar spent for various components of medical service has changed with each survey. Expenditures for physicians services have decreased from 37% in 1953 to 34% in 1958 and to 31% in 1963.

Hospital expenditures have increased from 19 to 23 to 26, dentists from 16 to 15 to 13. Drugs absorbed 15% of the medical dollar in 1953, went up to 20% by 1958 and stayed the same (20%) in 1963.

More interesting than any other statistic is the disparity demonstrated to exist between families in the amount they spend for medical care. For instance, 30% of the families spent less than $100 each, and accounted for only three percent of the total of all families. At the other end of the sale, eight percent of the families spent more than $1,000 per year and accounted for 36% of the grand total. No proof, other than this, is necessary to validate the widespread use of medical health insurance.

Changes in the proportion spent for physicians, hospital, dentists, etc., are brought about principally by the increases in hospital costs, which in turn are due to introduction of more elaborate and expensive procedures, the increase in number and technical ability of personnel, and better rates of compensation for hospital employees. These three factors, in the opinion of George Bugbee, Director of the Health Information Foundation, will continue to influence hospital costs in the future, presumably by increasing more and more and thus will further alter the composition of the "Medical Care Dollar."

Guest Editorials

Quackery

"PHYSICIANS, as conservators of the public health, are bound to bear emphatic testimony against quackery in all its forms."

Is this a quote from proceedings of the American Medical Association's Clinical Convention in Philadelphia last December?

The meeting was in Philadelphia, but the year was 1847!

So you see, from its very inception 118 years ago, the American Medical Association has been battling quackery and it is dedicated to a continuation of this warfare against wasting the nation's health and its health care dollar . . . of fighting fraud at the bedside of ill and desperate people.

For, as long as there are human beings, there will be human nature . . . and quacks — pretenders to ability they don't possess — to take advantage of the fact.

The health quack is not so easy to spot these days. The stovepipe hat and the pitchman's hawking have gone. In their place are their space-age counterparts, the suave, apparently-sophisticated super salesmen with the Madison Avenue manners.

These merchants of menace, more insidious and unscrupulous than ever, have many new products, worthless diet fads, worthless food supplements, worthless cosmetic devices and treatments, worthless "cures" for everything — even into the area of brain-damaged children and other mental illness.

They bilk the undiscerning — the uninformed, the desperate, the unsuspecting of all ages — of millions of dollars a year. The estimates of the costs of medical quackery are at best calculated guesses, but they have gone as high as a billion dollars a year. And one authority in the field of quack-fighting has stated that "medical quackery each year costs more lives than all crimes in the United States."

It is this cost of life — and health — that has placed America's physicians in the front lines of the war on quacks. It is the insidious side-effect of quackery with which medicine concerns itself — the delay in proper medical care that may cost life itself.

It is for this reason, too, that the medical profession is dedicated to education of the people about cultism — chiropractic and the other health sects that turn their backs on scientific medicine.

The House of Delegates of the American Medical Association said in 1933:

"Either the theories and practices of scientific medicine are right and those of the cultists are wrong, or the theories and practices of the cultists are right and those of scientific medicine are wrong."

And in 1961, it said:

"There can never be a majority party and a minority party in any science . . . ."

After the quack or the cultist has extracted his pound of flesh — after the damage is done and after the sick may have become the dying because of the delay in proper care — scientific medicine usually is called upon to pick up the pieces.

Medicine has tried and will continue to try to do that job, too, but how much easier the job would have been — how many lives would have been saved — if . . . . **Suggested editorial from the AMA.**

On Shock

OLDER doctors knew more about shock than we do, and they knew considerably less. It was a clinical picture to them, one of a man who had been trampled by a horse, and who was cold and clammy, whose pulse was rapid and thready, and who did not respond well to questioning. But on the other hand, they knew little or nothing of arterial blood pressure, and we must point out that a thready pulse is hard to define. We know a great deal now about hypotension and how to take blood pressure, but when the older physician said a patient was in shock, he meant something, and we do not. We speak of primary and of secondary shock, of neurovascular shock, of delayed shock, of initial shock, of neurogenic shock, of true shock, of surgical shock, of hemorrhagic shock, of bacteremic shock, and of hypovolemic shock. But these people have not all gone into shock, whatever that means, and they do not all look the same.

It would be far better if we redefined the word, or if we gave it up altogether. If a patient's systolic arterial blood pressure has fallen, we have only to say so. If he has lost more blood than is good for him, it is easy

to say that he has. In a state of shock is a phrase that is bandied about too much, and unfortunately often by us. It appears daily in the news media, along with accounts of people who collapse one day and are well the next. Our suggestion is to give up the word completely. We no longer are trampled by horses, and while shock has come to mean less and less until it means nothing, it is used more and more, to embrace a host of conditions where it does not apply. Let us say hypotension when that is what we mean.

We even read of the treatment of irreversible shock, and there is something to conjure with — Frank Cole, M.D., Editor, *The Nebraska State Medical Journal* 51:357, Sept., 1966.

Highway Holocaust

More than 4,000,000 persons were killed or injured on U.S. highways in 1965.

This grim message is contained in The Travelers Insurance Companies annual highway accident booklet, which reports 48,500 deaths and 4,100,000 injured last year. Statistics in the booklet were compiled from reports by state motor vehicle departments.

The trail of death and destruction in 1965 marked the first time the casualty count has exceeded the 4,000,000 level. Fatalities increased by one percent over 1964; injuries were up by seven percent.

Young drivers — those under 25 years of age — again led the list of offenders. And their collective record in 1965 was substantially worse than in any previous year.

Although these younger persons represent only about 18% of all licensed drivers, they were involved in more than 30% of all fatal accidents and 28% of all non-fatal mishaps.

"Sooner or later," says a Travelers spokesman, "the traffic toll will reach proportions where the nation will no longer tolerate such destruction on the highways."

The company in 1965 announced it would sponsor a massive research program designed to study man and his environment. The first phase of this program will deal with man and the automobile and will include research on the interaction of the driver, the car and the environment.

Travelers already has invested $250,000 in this study and expects to contribute thousands more as research continues.

How to Beat the Antivivisectionists

When it comes to combating the tearful testimony of the various antivivisectionist groups, we may be required to become just as emotional by using the testimony of grateful people who now live because of the contribution animals have made to medical knowledge. We must not be complacent. This is the year for the antivivisectionist—unless we combat emotions with truth. — Daniel B. Powell, M.D., in *Texas Medicine*, (62:27-28), February, 1966.

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Effective in a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill—when the offending organisms are tetracycline-sensitive.

Contraindication—History of hypersensitivity to demethylchlortetracycline.

Warning—In renal impairment, usual doses may lead to excessive systemic accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort.

Precautions and Side Effects—Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. Use of demethylchlortetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect occurs mostly during long-term use but has also been observed in short treatment courses. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment. Side reactions include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and dermatitis. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Anaphylactoid reactions have been reported.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products.

Capsules: 150 mg; *Tablets:* film coated, 300 mg, 150 mg, and 75 mg of demethylchlortetracycline HCl.

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Behind continued high blood pressure readings lies the possibility of organic damage[1-13]

MANY OF THE aspects of essential hypertension are unpredictable—either because there are a number of mechanisms involved or because individuals differ in their responses to these mechanisms.[1]

There is one aspect of hypertension, however, that seems, in many cases, predictable. ". . . when the blood pressure is elevated to a marked degree for an adequate period of time, this in itself leads to perpetuation of the syndrome with resulting vascular damage throughout the body."[14] All too often the disease progresses until there is damage to one of three vital organs: the heart, the kidney, the brain.

"Hypertension is certainly a major factor in the genesis of coronary heart disease, and it is even more important when compounded with obesity."[4]

"[Vascular deterioration] can be clearly seen in the kidney with a degree of damage that can be measured by renal function studies."[10]

". . . most evidence suggests that reduction of blood pressure, when it is too high, not only relieves the heart of excess work but reduces vascular damage."[1]

"In short, treatment is indicated."[1]

Antihypertensive therapy will not restore the blood vessels to normal. Yet many of the vascular changes and symptoms caused by increased blood pressure may be arrested or alleviated when the blood pressure is reduced to normotensive levels.[7]

Reducing the blood pressure helps curtail further vascular damage and improves the prognosis — when damage is not too far advanced before therapy is started.[14] Essential hypertension is an indication not only for treatment, but for *early* and adequate treatment of the patient in question.

Reduce the blood pressure with Rautrax-N

Rautrax-N combines the antihypertensive-tranquilizing action of whole root rauwolfia with the antihypertensive-diuretic action of bendroflumethiazide in one convenient medication. The two drugs complement each other so that smaller doses of both are possible.

Rauwolfia combined with bendroflumethiazide is particularly effective in long-term therapy,[15-17] since beneficial effects do not diminish with continuous daily administration.

For most patients 1 or 2 Rautrax-N tablets daily are sufficient for maintenance therapy. The simplicity, convenience and economy of such a dosage schedule are of particular benefit to older patients.

References: 1. Page, I. H., and Dustan, H. P.: The Usefulness of Drugs in the Treatment of Hypertension, in Ingelfinger, F. J.; Relman, A. S., and Finland, M.: Controversy in Internal Medicine, Philadelphia, W. B. Saunders Co., 1966, p. 95. **2.** Hollander, W.: The Evaluation of Antihypertensive Therapy of Essential Hypertension in Ingelfinger, F. J.; Relman, A. S., and Finland, M.: Controversy in Internal Medicine, Philadelphia, W. B. Saunders Co., 1966, p. 97. **3.** Nickerson, M.: Antihypertensive Agents and the Drug Therapy of Hypertension, in Goodman, L. S., and Gilman, A.: The Pharmacological Basis of Therapeutics, ed. 3, New York, The Macmillan Co., 1965, p. 727. **4.** Berkson, D. M.: Indust. Med. & Surg. **32**:371, 1963. **5.** Cohen, B. M.: M. Times **91**:645, 1963. **6.** Lee, R. E., et al.: Am. J. Cardiol. **11**:738, 1963. **7.** Moyer, J. H.: Am. J. Cardiol. **9**:821, 1962. **8.** Moser, M.: New York J. Med. **62**:1177, 1962. **9.** Wood, J. E., and Battey, L. L.: Am. J. Cardiol. **9**:675, 1962. **10.** Moyer, J. H., and Heider, C.: Am. J. Cardiol. **9**:920, 1962. **11.** Moser, M., and Macaulay, A. I.: New York State J. Med. **60**:2679, 1960. **12.** Judson, W. E.: Nebraska M. J. **44**:305, 1959. **13.** Hodge, J. V.; McQueen, E. G., and Smirk, H.: Brit. M. J. **1**:5218, 1961. **14.** Moyer, J. H., and Brest, A. N.: Hypertension Recent Advances, Philadelphia, Lea & Febiger, 1961, p. 633. **15.** Berry, R. L., and Bray, H. P.: J. Am. Geriatrics Soc. **10**:516, 1962. **16.** Reid, W. J.: J. Am. Geriatrics Soc. **13**:365, 1965. **17.** Feldman, L. H.: North Carolina M. J. **23**:248, 1962.

Contraindications: Severe renal impairment or previous hypersensitivity. **Warning:** Ulcerative small bowel lesions have occurred with potassium-containing thiazide preparations or with enteric-coated potassium salts supplementally. Stop medication if abdominal pain, distension, nausea, vomiting or G.I. bleeding occur.

Precautions and Side Effects: The dose of ganglionic blocking agents, veratrum or hydralazine when used concomitantly must be reduced by at least 50% to avoid orthostatic hypotension. Caution is indicated in patients with depression, suicidal tendencies, peptic ulcer; electrolyte disturbances are possible in cirrhotic or digitalized patients. Marked hypotension during surgery is possible; consider discontinuing two weeks prior to elective surgery and observe patients closely during emergency surgery. Rauwolfia preparations may cause reversible extrapyramidal symptoms and emotional depression, diarrhea, weight gain, edema, drowsiness may occur. Bendroflumethiazide may cause increases in serum uric acid, unmask diabetes, increase glycemia and glycosuria in diabetic patients, and may cause hypochloremic alkalosis, hypokalemia; cramps, pruritus, paresthesias, rashes may occur.

Dosage and Supply: Initial dosage, 1 to 4 tablets daily, preferably at mealtime. Maintenance, 1 or 2 tablets daily. Rautrax-N is supplied as capsule-shaped tablets containing 50 mg. Rauwolfia serpentina whole root (Raudixin®), 4 mg. bendroflumethiazide (Naturetin®), 400 mg. potassium chloride.

Also available: Rautrax-N Modified — capsule-shaped tablets containing 50 mg. Rauwolfia serpentina whole root (Raudixin), 2 mg. bendroflumethiazide (Naturetin), 400 mg. potassium chloride. Both potencies available in bottles of 100. For full information, see Product Brief.

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Squibb Rauwolfia Serpentina Whole Root (50 mg.) with Bendroflumethiazide (4 mg.) and Potassium Chloride (400 mg.)

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EUGENE S. RIFNER, M.D.

President

Indiana State Medical Association

1966-67

Dr. Eugene S. Rifner, busy general practitioner from Van Buren, succeeded to the presidency of the Indiana State Medical Association at French Lick during the annual convention.

Dr. Rifner received the gavel, emblematic of the office, from Dr. Kenneth O. Neumann, after an extremely active year for both of them as president-elect and president of the association.

Dr. Rifner was born in Indianapolis, graduated from high school in Spiceland and attended Indiana University, from which he received an A.B. degree in chemistry in 1942 and an M.D. degree in August, 1945. After an internship in St. Vincent's Hospital in Indianapolis, he served as a captain in the Medical Corps of the Army until 1948.

He has practiced medicine in Van Buren since that time and has been increasingly active in medical societies and in civic affairs. He was secretary-treasurer of the Grant County Medical Society for eight years; was then appointed to the ISMA Commission on Public Health and was especially active in the conduct of several of the highly successful Junior-Senior Day programs.

He was elected to the Council from the 11th District in 1960, was chosen its chairman in 1964 and, as councilor, served on the liaison committee with Blue Cross.

Dr. Rifner is an active member of the Indiana Academy of General Practice and has served as president of its 11th Indiana District. He is a staff member of the Marion General Hospital and has been Chief of Obstetrics and also secretary of the medical staff of that hospital.

He and his wife, Elissa, have four children, Ann, Gregory, Douglas and Nicole. Fourteen-year-old Doug may be the next Dr. Rifner.

Dr. Rifner's civic activities in Van Buren include the Central Christian Church, the Masonic Lodge, the Lion's Club, the American Legion and the Van Buren Chamber of Commerce. He is also a member of the Scottish Rite and the Shrine in Fort Wayne.

President's Page

Dear Doctor:

By the time this goes to print, the convention of the Indiana State Medical Association will be over. Policies will be set there that may, or may not, be the same as those policies which have been set in the past. As your president, I shall endeavor to do my best to carry out the policies of the Indiana State Medical Association House of Delegates. I shall also make every effort to keep the administration of these policies in line with the progress of modern day living.

We are coming to a period when the State Legislature will soon meet. I would urge that you make known to your state senator and your state representatives your opinions concerning health legislation. Your Legislative Commission will be meeting almost weekly during January and February. Most of your officers will also be present and give up large amounts of time to this. Our staff, especially Robert Amick and Howard Grindstaff, will spend many, many hours in the halls of the State Capitol. I sincerely hope that our successes will equal or be more than those we have had in past State Legislatures.

I should also like to express my personal, and I believe the Indiana State Medical Association's, appreciation to Dr. Kenneth O. Neumann for his devoted service to organized medicine over the past 10 or 12 years. His knowledge and record are certainly to be envied. In my short tenure in the Indiana State Medical Association, I have met no man within this organization, no matter how far he may have gone within ISMA or within AMA, who is as well versed and has shown as much devotion to the duties of the offices he held as Dr. Neumann. Dr. Neumann, we thank you for the heritage, for the guidance, and for the objectives you have set for this organization in the future.

In spite of Medicare, and in spite of welfare programs that are not completely worked out to our satisfaction, you and I as American citizens have much to be thankful for this Thanksgiving. As we sit around our Thanksgiving table with our families this November 24, let us be thankful for the freedoms of America that still remain. Let us pray to God that we show our gratitude for the abundance of life at present and ask Him for guidance in our every effort to preserve and strengthen freedom for all men.

Eugene S. Kiefner M.D.

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Contraindications
Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. Because of the increased possibility of toxic reactions, the drug should be used with greater care in the elderly and should not be given when the patient is senile or when other potent chemotherapeutic agents are given concurrently. Large doses of Butazolidin alka are contraindicated in patients with glaucoma.

Warning
If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

Use with caution in the first trimester of pregnancy.

Precautions
Before prescribing, the physician should obtain a detailed history and perform a complete physical and laboratory examination, including a blood count. The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made to guard against blood dyscrasias.

Adverse Reactions
The most common adverse reactions are nausea, edema and drug rash. Moderately lowered red cell count may sometimes occur due to hemodilution. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vertigo or languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects.

Confusional states, hyperglycemia, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

Dosage
The initial daily dosage in adults is 300-600 mg. daily in divided doses. In most instances, 400 mg. daily is sufficient. When improvement occurs, dosage should be decreased to the minimum effective level: this should not exceed 400 mg. daily, and is often achieved with only 100-200 mg. daily.

For complete details, please refer to full prescribing information.
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The Woman's Auxiliary

REPORTS TO ISMA

In early October, Roberta Deever and I attended the fall conference for state presidents and presidents-elect in Chicago. This was followed by the North Central Regional Workshop to which six of our state chairmen were invited; AMA-ERF, community service, legislation, membership, mental health and health careers. Three more workshops, Eastern, Southern and Western Regions, followed. Thus eight women from each state were briefed in the most important phases of program (study and action) as decided upon by national's officers and chairmen.

Speakers for the conference, brought in from outside organizations, included Ellen Winston, Ph.D., Commissioner, Welfare Administration, HEW; Charles Hudson, M.D., President of AMA; Howard Hassard, Executive Director, California Medical Association and Henry I. Fineberg, M.D., Executive Vice President, Medical Society of the State of New York. These four discussed Title 19. Later, representing "Action Programs," came a director from the Office of Volunteers, American Red Cross; a representative of the American Farm Bureau's Women's Division and the chairman of the Education Fund, League of Women Voters. Another speaker was Dean W. Roberts, M.D., Executive Director of the National Commission on Community Health Services, Inc., whose topic was "Health Is a Community Affair." An entire half-day session was devoted to "Project Vietnam." This was introduced by a most informative and challenging address by His Excellency Vu Van Thai, Ambassador of Vietnam. Norman Hoover M.D., Department of Orthopedics, Mayo Clinic, a four-time volunteer to Vietnam and other speakers explained the AMA physician volunteer project, the medical assistance program and how the auxiliary can "also serve."

Direct Service Projects for the Homebound and Elderly, namely, Meals-on-Wheels, Homemaker Service and Volunteer Friendly Visitor Training, were presented by their respective national chairmen. The other half of program emphasis for the year, "Good Health of School-age Children and Youth" had been presented at the convention in June. This included suggested materials for a concerted attack on the too prevalent community ignorance and apathy in regard to venereal disease, mental health, safety, physical fitness, etc. Seven package programs currently available from national are:

Immunization
Youth Health and Fitness
Teen-age Venereal Disease Control
Timely Attention to the Mental Health of Children
GEMS (Good Emergency Mother Substitutes)
The Block Mother Plan
Health Careers

This is our challenge for the months ahead. It was presented to your wives who attended our workshop in French Lick. Will you, after reading this, encourage them to look for opportunities to alert and help educate your communities to these outstanding medically-related needs?

As we approach the season of Thanksgiving, may our gratitude well up from our hearts that are free because they are consecrated. Because it is consecrated, the free heart not only appreciates its own freedom but longs for the same freedom for others. This longing it puts into action; a symbol of our thanksgiving is our thanksgift.

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Medical Panorama

The ACS Speaks Out

A. W. CAVINS, M.D.
Terre Haute

AT long last an authoritative organization of the medical profession has taken notice of unwise publicity in regard to new procedures —in this instance, new operations. The Board of Regents of the American College of Surgeons has done this and has repeated its policy in *FACS Newsletter*, Vol. 1: No. 1, July, 1966. Since the same ethical and scientific point-of-view should apply equally to the other fields of medicine, the short article is herewith quoted in fu'l:

"Recent publicity regarding new operations has occasioned widespread concern among the Fellows of the American College of Surgeons in the United States, Canada and abroad.

"Therefore, the Board of Regents is obliged to enunciate again the policy of the College regarding publicity.

"Traditionally, announcements of surgical innovations have first been made to professional audiences and have been followed by reports in scientific journals before appearing in newspapers and lay periodicals. This permitted substantiation of the initial findings by other investigators, and served as a safeguard to protect patients and surgeons alike. It also assured appropriate acknowledgment of the contributions of others who have worked in the same field.

"In recent years this time-tested principle of medical practice has been impaired by pressures for the rapid dissemination of any news which may be of interest to the public. Surgeons have been importuned to report their early 'successes' although new procedures can be fairly evaluated only upon long-term results.

"Therefore, a surgeon should consider conscientiously whether his early results should receive publicity outside of professional channels. He has a responsibility to many, including his colleagues in his own community.

"If he sincerely believes that a public announcement is in the best interest of all concerned, he first should seek consultation with appropriate members of the medical or scientific community. In many areas organized medicine has established acceptable channels for consultation.

"He should strive with equal sincerity to secure the cooperation of the hospital administration, the public relations department and related communications media in presenting new developments with propriety.

"Those in the communications field also share a common responsibility with the medical profession to exercise the restraint necessary to avoid intimations which raise unjustified hopes.

"Within his own domain the surgeon has the final responsibility for avoiding and preventing unwise publicity."

Will those "in the communications field" please note?

In this connection, credit should be also to the American College of Obstetricians and Gynecologists for establishing liaison with certain journals published for women with a view to increasing the accuracy and reducing the sensationalism in articles concerning gynecology and obstetrics. This has been going on for some time and where a meeting of the minds has been accomplished, much good has resulted. ◄

The Bureaucrat and the Doctor

A spokesman for medicare, commenting on a report that doctors have raised their fees for elderly patients by "as much as 300%" since the program began, jumped to a hasty and predictable conclusion. "This is a situation," he told *The New York Times*, "in which the professional takes advantage of the plan."

What *The Times* report boiled down to was simply that many doctors who have been treating the elderly and indigent at cut-rate fees, out of consideration for these patients, are raising the fees to conform to their standard fees. "I'm not raising fees," one doctor protested, "but eliminating a discount."

This doesn't strike us as unreasonable. There is no reason why a doctor who has been helping elderly patients by charging less than the going rate should now be expected to grant the same subsidy to the government — especially when he is paying Social Security taxes himself for benefits which, in all likelihood, he will never receive. Doctors rarely retire at 65, and with today's shortage there is more need than ever for them to stay on the job.

If the government, for its part, wants the elderly to receive the quality of care that they have been promised under the voluntary, supplemental program to which nearly all of them have subscribed, it hardly makes sense for it to refuse to pay what other patients pay.

This isn't to say that all doctors are perfect or that there won't be any abuses on their part. But when a government spokesman suggests that the medical profession is profiteering simply because doctors object to subsidizing the government more than they already are, the doctors can't be blamed for looking at the whole program with a jaundiced eye.

This is the way schisms have developed between doctors and burocrats wherever a government has stepped into the practice of medicine. If it is an indication of the way things are to be here, too, the prognosis for Medicare is a gloomy one. — *Chicago Tribune*, 8-27-66.

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The obese patient on a diet often has to battle depression as well as overweight. Desoxyn Gradumet helps the dieter in both battles by elevating the mood while it curbs the appetite. Thanks to the Gradumet, medication is smoothly released all-day from a single oral dose.

If she can't take plain amphetamine, put her on DESBUTAL® Gradumet

Calms anxieties; controls compulsive eating.

Desbutal Gradumet provides 2 drugs in 2 tablet sections, combined back to back to form a single tablet. One section contains Desoxyn to curb the appetite and lift the mood; the other contains Nembutal® (pentobarbital) to calm the patient and counteract any excessive stimulation.

Both drugs are released in an effective dosage ratio throughout the day.

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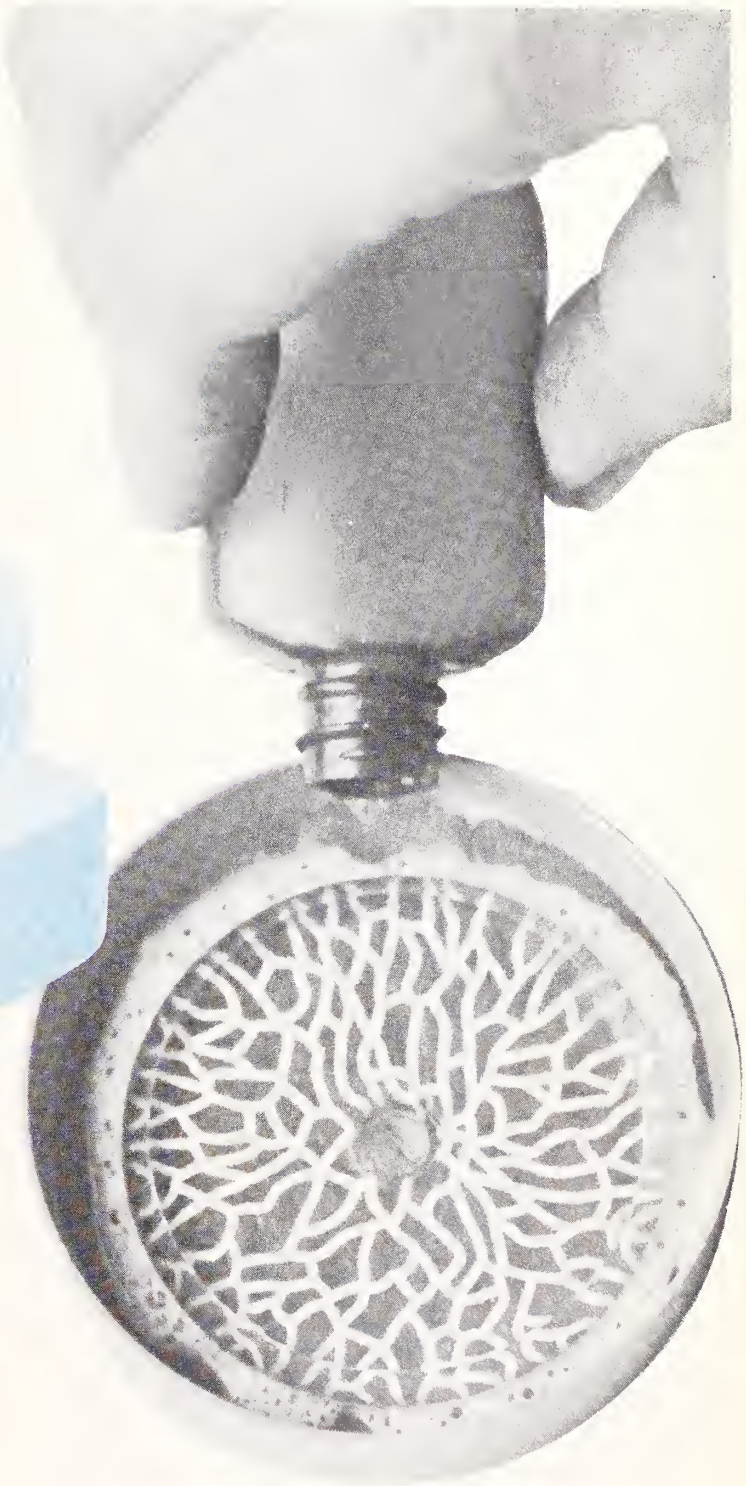
Not all long-release vehicles are the same. Here is why the Gradumet is different and what it means for your overweight patients.



The release action is purely physical and relies on only one factor common to every patient: gastrointestinal fluid. There is no dependence on enteric coatings, enzymes, motility, or an "ideal" ion concentration in the gastrointestinal tract.

Your patients get a measured amount of medication, moment by moment, throughout the day.

They are not subjected to ups and downs of drug release . . . or to erratic release from patient to patient . . . or to erratic release in the same patient from day to day.

That's why the Gradumet provides controlled-release as well as long release.

Perhaps you saw the Gradumet model demonstration which shows that the release is entirely physical. When fluid is added, the drug in the outer ends of the channels dissolves. As fluid penetrates deeper into the channels, there is a continuous release of medication. The rate of release is rigidly controlled by the size and number of channels.

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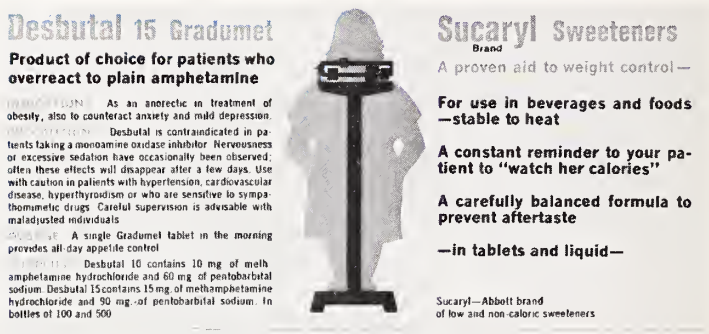

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Product of choice for patients who overreact to plain amphetamine

As an anorectic in treatment of obesity, also to counteract anxiety and mild depression.

Desbutal is contraindicated in patients taking a monoamine oxidase inhibitor. Nervousness or excessive sedation have occasionally been observed; often these effects will disappear after a few days. Use with caution in patients with hypertension, cardiovascular disease, hyperthyroidism or who are sensitive to sympathomimetic drugs. Careful supervision is advisable with maladjusted individuals.

A single Gradumet tablet in the morning provides all-day appetite control.

Desbutal 10 contains 10 mg. of methamphetamine hydrochloride and 60 mg. of pentobarbital sodium. Desbutal 15 contains 15 mg. of methamphetamine hydrochloride and 90 mg. of pentobarbital sodium. In bottles of 100 and 500.

Sucaryl Brand Sweeteners

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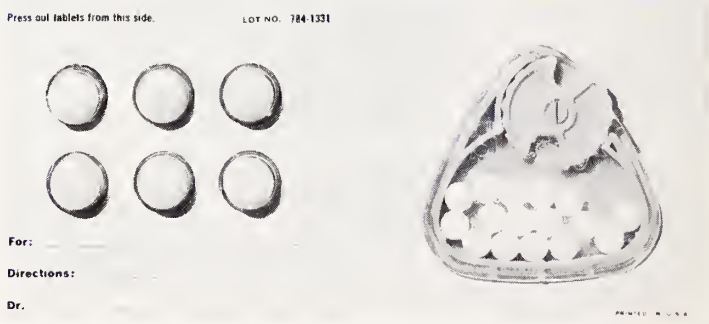

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For:

Directions:

Dr.

economy

Patients, in many cases, save enough to get five weeks of medication for the price of four, compared to other leading long-release anorectics.

CONTRAINDICATION: Desoxyn and Desbutal are contraindicated in patients taking a monoamine oxidase inhibitor.

PRECAUTIONS: Use with caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs or ephedrine and its derivatives. Careful supervision is advisable with maladjusted individuals.

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Gradumet—long-release dose form, Abbott: U.S. Pat. No. 2,987,445.
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Gleaned from the British Medical Journal

JACK W. HICKMAN, M.D.
Indianapolis

Prefontal Lobotomy Re-evaluated

Sargant, Walter, and Wright[1] report their results with 73 patients who were referred to them for leucotomy for chronic tension states. All these patients had been refractory to therapy and were largely referred by other psychiatrists. The study group therefore was composed of particularly difficult problem cases. Prior to leucotomy, all patients were given intensive drug therapy with a variety of antidepressant agents, psychotherapy, and in most cases, E.C.T. The encouraging part of the report is that only 18 of the 73 patients eventually required leucotomy. The authors feel that the narcosis part of their therapy plan was an important therapeutic adjunct. They also thought that a previous "good personality" had strongly favorable prognostic importance, even more so than the duration of illness.

Chronic Radiation and Damaged Chromosomes

A fascinating long-term follow-up study is reported by Boyd et al.[2] These authors performed chromosome analysis studies on 62 women who had been employed as luminous watch dial painters from 1939 to 1945. All had received $Radium^{226}$ exposure at this time, although it was believed that the total dose that they received was quite low. It was found that these subjects showed a higher incidence of structurally abnormal chromosomes than would have been expected in the normal population. The incidence of chromosome anomaly was also found to be related directly to the dose of $Radium^{226}$ exposure. Long-term statistical studies of the progeny of these workers will also add to our knowledge of radiation hazards.

Sympathectomy Flunks Lab Tests But Helps Four Out of Ten

A paper by Myers and Irvine[3] certainly starts out with a true statement: "The value of lumbar sympathectomy for intermittent claudication is disputed." These authors studied 31 such patients by means of plethysmography to determine blood flow before and after surgery. The adequacy of the sympathectomy was evaluated by a standard sweating test. They were unable to demonstrate any laboratory evidence for increased blood flow by the procedure by measuring resting flow, peak flow, and arterial pressures. Despite these negative results, the paper points out that 13 of the 31 patients gratefully experienced more than doubling their "claudication distance" after the sympathectomy was performed. This fact pretty well brings us full circle to the opening sentence of the paper.

Sed Rate is Normally Higher in Oldsters

An elevated erythrocyte sedimentation rate (E.S.R.) usually sends up a red warning flag to the attending physician, alerting him to continued activity of some pathologic process. Accordingly, a falsely elevated E.S.R. can lead both patient and physician through a lengthy, costly, and unrewarding trail of laboratory procedures. This makes the report of Boyd and Hoffbrand[4] of particular value. They found 303 "falsely" elevated E.S.R.'s in a group of patients over 65 years of age. They conclude that the true upper limit of normal for the E.S.R. in these older patients should be 40 mm./hr. rather than the usual 20 mm./hr. Nearly a third of the patients they studied had values over 40 mm./hr., and these were patients with no detectable disease. The authors do not claim priority for this finding, but certainly previous reports have not received the wide dissemination that they deserve.

BIBLIOGRAPHY

1. Sargant, W., Walter, D.J.S., Wright, N.: New Treatment of Some Chronic Tension States, *Brit. Med. J.* 5483:322-324.
2. Boyd, J. T., Brown, W. M. Court, Vennart, J., Woodcock, Gillian E.: Chromosome Studies on Women Formerly Employed as Luminous-dial Painters, *Brit. Med. J.* 5484:377-382.
3. Myers, K. A., Irvine, W. T.: An Objective Study of Lumbar Sympathectomy I. Intermittent Claudication, *Brit. Med. J.* 5492:879-883.
4. Boyd, R. V., Hoffbrand, B. I.: Erythrocyte Sedimentation Rate in Elderly Hospital In-patients, *Brit. Med. J.* 5492:901-902.

Coronary Care Unit: St. Vincent's Hospital

IN the past few years, the annual mortality from coronary heart disease in the U. S. has exceeded a half million people. Eighty-five percent of the deaths from acute myocardial infarction occur within the first week of the acute attack. The vast majority of these deaths result from cardiac arrhythmia, cardiogenic shock or cardiac failure, alone or in combination.

In coronary care units over the country and also in our own general intensive care units in this city, there has been a significant reduction in mortality by utilizing intensive coronary care. If lethal cardiac arrhythmias such as ventricular fibrillation, ventricular tachycardia and asystole are promptly detected, diagnosed and treated by the application of modern technics, there will undoubtedly be a significant reduction in the mortality occurring in the first week.

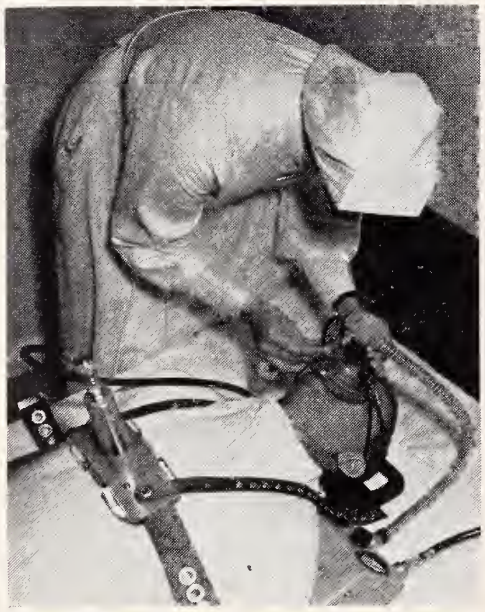
The new concept of "electrical treatment of coronary occlusion" along with the time-honored treatment with drugs can not only reduce mortality but also can significantly reduce the morbidity accompanying coronary heart disease.

Strategically Located

The Coronary Care Unit at St. Vincent's Hospital consists of four beds. These beds are all in private cubicles and the unit is designed so that each patient will be in constant vision of the charge nurse. The unit is in close proximity to the intensive care unit and to the house staff quarters as well as nearby the surgery and the x-ray department. Each unit is designed so that adequate space is available for all bedside emergencies.

At present the purpose of the Coronary Care Unit is fourfold:

1. To provide constant and intensive nursing and medical care to all patients admitted to the hospital with either acute coronary occlusion and myocardial infarction or complex and dangerous cardiac arrhythmias that imperil the patient's life.



SISTER Mary Emily, supervisor of Intensive Care and Coronary Care, adjusts the face mask of the Automatic Heart Lung Resuscitator. The chest portion of the apparatus delivers a measured impulse to the sternum and anterior chest to accomplish controlled external cardiac resuscitation while the respiratory element performs automatic breathing at the ratio of one respiratory cycle to each five cardiac stimulae. The "patient" is Mr. George Foss, Administrative Assistant, St. Vincent's Hospital. He enjoys the "distinction" of being the unit's first patient, and its best example of the salutary effects of emergency treatment; he resumed his work the same day and has worked steadily ever since. — North Side Topics photo.

2. To teach and train members of the house and nursing staffs in all phases of cardiac resuscitation which also includes defibrillation, "cardioversion" and automatic pacing of the heart.

3. To closely study the results of coronary intensive care, both in regard to clinical research and training of the house and nursing staffs.

4. To evaluate the merits of constant cardiac monitoring systems for a minimum of three days or a maximum of seven days, except in unusual circumstances.

At each bedside is a monitor that in a sense is portable in that it is mounted on a hinged stand and can be moved away from or to the wall next to the patient's bed. The six inch oscilloscope is in full view of the nurse at all times. In addition to the oscilloscope, the monitor also contains an alarm system, both for an unusually rapid rate or an unusually slow rate or asystole, and an internal and external pacemaking unit that can be used either for automatic, continuous or demand pacing.

"Memory" Module

At the central nursing station, a rate meter is present for all beds and there is also a "memory loop" module that is capable of storing electrocardiogra-

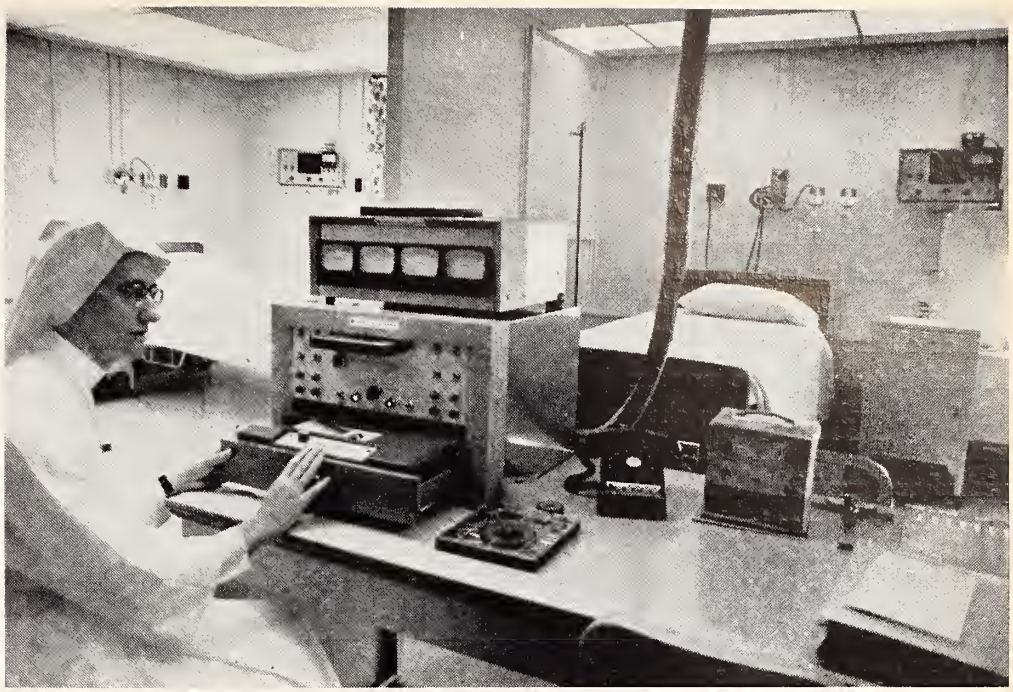
phic information on tape up to five minutes prior to the onset of the cardiac arrhythmia. This tape can be stored and played back at any time at the physician's request.

The unit contains a complete cardioverter and defibrillator unit which is also equipped with an electrocardiographic instrument that can be turned on at any time to record rhythm strips or an entire electrocardiographic tracing if so indicated. A cardiopulmonary resuscitator is in the unit and this can be quickly applied to the patient so that one individual is able to give external cardiac massage and pulmonary resuscitation in a ratio of five to one.

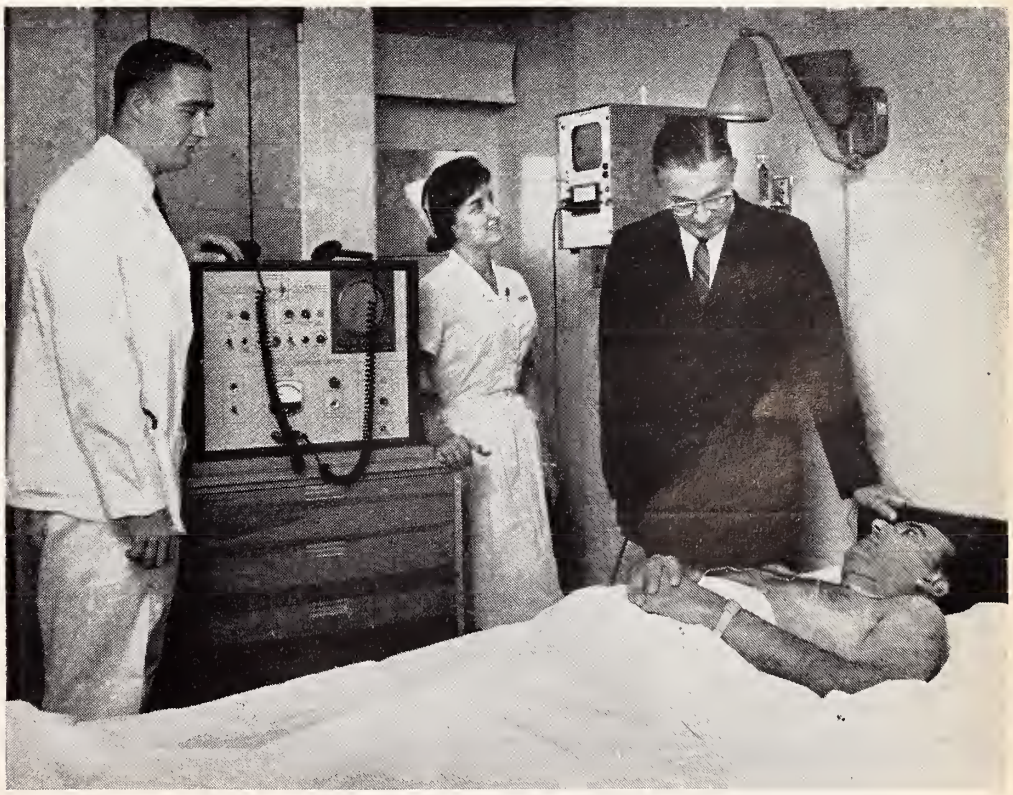
The resuscitator is cycled so that for each five external cardiac compressions, there will be one forced positive pressure ventilation of the lungs. All other emergency equipment, such as a resuscitation board, airways, laryngoscopes, Levin tubes and all necessary cardiac drugs will be kept in the unit at all times. Cardiac catheters for internal pacing of the bipolar type as well as a portable pacemaker both for internal and external pacing, are available in the unit but the latter can be transported anywhere in the hospital.

Bedside suction and oxygen is available in each of the four cubicles. Each cubicle is individually lighted and has its own electrical system. The unit is attractive with curtains covering the opening to the patients' cubicles so that each patient can have all the privacy that might be necessary, and at the same time be observed by the head nurse or the physician constantly.

Each individual patient will be monitored constantly during his stay in the Coronary Care Unit. It will be up to the private attending physician to determine whether the patients will be allowed to use bedside commode, bedpan, etc. The family waiting room is far enough removed from the Coronary Care Unit so that relatives will not be constantly in the way of nurses during an emergency. Visiting hours will be more lax than in the general intensive care units because of the



THE interior of the St. Vincent's Hospital Coronary Care Unit with Sister Emily at the console of the American Optical Company Central Monitor. The bedside monitors and the oxygen and suction vent appliances are visible in two of the four patient units. The central monitor records on magnetic tape five minutes of ECG record which may be reproduced at any time. It also contains an alarm system for disturbed rhythms, a ratemeter for each patient and a ECG writer. The small device to the right of the telephone is a battery operated portable pacemaker.



THIS picture was taken at the Methodist Hospital coronary care unit with hospital executive Robert Suckow acting as the "patient." The equipment is checked by (left to right) Dr. William Storer, Miss Glenda Cunningham and Dr. I. E. Michael. — Indianapolis Star Photo.

privacy that is afforded.

Constant Supervision

Each patient admitted to the Coronary Care Unit will be under the direct care of his attending physician. All members of the internal medicine and general practice section have received complete detailed information in the use of all the equipment. The unit is headed by a full-time nursing supervisor and each shift has a charge nurse and an L.P.N. who are especially picked and qualified and who have had an intensive course in the field of coronary heart disease, electrocardiography, resuscitation, defibrillation, cardioversion, etc.

It is hoped that these nurses will be able to interpret dangerous cardiac arrhythmias such as ventricular fibrillation, tachycardias, standstill and other dangerous cardiac arrhythmias that might endanger the patient's life, and either immediately contact a member of the house staff or the private physician, or in certain isolated instances, go ahead with the electrical treatment as indicated. A member of the house staff is on call at all times. Periodic teaching and training programs for the house staff will be initiated and will be the direct responsibility of the unit director and the director of medical education.

A Coronary Care Unit committee has been established consisting of three members from the section of internal medicine and one member from the department of general practice. The chairman of the Coronary Care Committee is designated as unit director.

The unit director is responsible to the members of the attending staff in regard to their capability of using the various specialized electronic equipment. He is also responsible for initiating both house staff and nursing education. The director is further responsible for the overall personal surveillance including the physical coverage both in regard to house staff and nursing, completion of all necessary study and research forms and works closely with the utilization committee. The unit director will be appointed on an annual basis by the hospital administrator and/or the president of the medical staff of St. Vincent's Hospital.

All patients admitted to the Coronary Care Unit will be under the direct care of their private and personal physician. It is hoped that all patients with acute coronary occlusion or complex and dangerous cardiac arrhythmias will be admitted directly to the Coronary Care Unit. All patients admitted to the unit are immediately monitored and this monitoring is continued throughout the patient's stay in the unit unless specifically contraindicated.

Each patient admitted to the unit remains there for a minimum of three days and for a maximum of seven days unless the clinical course contraindicates. It is understood that emergencies will arise frequently and that immediate treatment shall be initiated by members of the nursing staff and of the house staff, who will work in very close cooperation with the attending physician or any member of the attending staff with special cardiology training who might be present and available immediately.

As in all other Coronary Care Units, very careful statistics are maintained throughout each patient's stay in the unit and a separate form is filled out on each patient admitted to the unit. It must be remembered by all members of the medical staff of St. Vincent's Hospital that coronary intensive care is primarily nursing intensive care and their full cooperation will be necessary and mandatory for this unit to function efficiently. ◄

J. HAL DORAN, M.D.
Unit Director
Coronary Care Unit
St. Vincent's Hospital

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MOLECULAR REMODELING—

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More than twenty-five years have passed since the discovery of the diuretic activity of sulfanilamide started pharmacologists on a succession of molecular remodelings to find the ideal diuretic.

Diuresis—a sought-after clinical effect from an unwanted side effect

It started in 1937 when a clinician reported that the administration of a sulfonamide was sometimes accompanied by an unexplainable side effect—metabolic acidosis.[1] Three years later the side effect was explained. The sulfonamide radical of sulfanilamide inhibited carbonic anhydrase,[2] the enzyme responsible for converting carbon dioxide and water to hydrogen ions and bicarbonate ions.

Later, other investigators showed by dog experiments that metabolic acidosis probably resulted when the inhibition of carbonic anhydrase upset the exchange of hydrogen and sodium ions, causing increased excretion of sodium as the bicarbonate.[3]

It was twelve long years after the first report of the unexplainable side effect (metabolic acidosis) that it was finally shown that large doses of sulfanilamide administered to edematous patients were indeed capable of promoting diuresis.[4] However, the possibility of toxic effects from its prolonged use and its relatively weak diuretic action made it impractical for clinical use as a diuretic.[5]

Because the inhibition of carbonic anhydrase seemed to be the key to effective diuresis, investigators began to look for more potent enzyme inhibitors —in the hopes that they would be more effective diuretics.

The most important of these early compounds, acetazolamide, enjoyed several years of fairly wide clinical use.

Its carbonic anhydrase inhibitory activity was several hundred times greater than that of sulfanilamide.[6] The increase in inhibitory activity, however, increased not only the excretion of sodium and bicarbonate ions, but also the excretion of potassium.[7] And, like its predecessor, acetazolamide precipitated mild acidosis. Its prolonged use could result in hypokalemic acidosis.[7]

The 'thiazides'—an answer to the metabolic acidosis caused by carbonic anhydrase inhibition

Despite the fact that the sulfonamide group appeared to be responsible for carbonic anhydrase inhibition which in turn appeared to be responsible for diuresis, investigators began to synthesize compounds with structural alterations to the sulfonamide group.

The first major breakthrough came with the synthesis of chlorothiazide. Altering the sulfonamide group did indeed alter the ability of chlorothiazide to inhibit carbonic anhydrase—it was only 1/10th as potent as acetazolamide in inhibiting the enzyme.[8] Despite the drop in inhibitory potency, however, chlorothiazide proved to be an effective diuretic—an observation that led to the conclusion that its diuretic action was due to some mechanism other than its action on carbonic anhydrase.[9,10]

For effective diuresis, chlorothiazide was administered in daily dosages ranging from 250 to 2000 mg.[11] It increased the excretion of sodium and chloride; and, to a lesser extent, potassium and bicarbonate.[11] The excretion of potassium appeared to be maximal at higher dose levels at which, theoretically, the carbonic anhydrase inhibitory effect is more active.[11] Its prolonged use, therefore, could sometimes result in metabolic hypokalemic, hypochloremic alkalosis.[7]

Naturetin—effective diuresis with more favorable electrolyte balance

Other thiazides followed—with improvements being aimed at two particular areas: 1. attempts to increase diuretic action in relation to the milligram potency of the drug, and 2. attempts at a more favorable sodium/potassium ratio in the urine, i.e., to decrease the excretion of potassium while maintaining the excretion of sodium.[12]

One of these, Naturetin, Squibb Bendroflumethiazide, has made advances on both these points. "By adding a 3-benzyl radical to hydroflumethiazide a rather dramatic reduction in dose range is accomplished. With this drug, effective sodium excretion is obtained with doses between 2.5 and 10 mg., which is a 200 to 1 ratio as compared to chlorothiazide..."[13]

Moreover, due probably to its virtual lack of carbonic anhydrase inhibition, Naturetin (bendroflumethiazide) has been shown to cause less potassium and bicarbonate loss and less alteration in urinary pH than either chlorothiazide or hydrochlorothiazide.

Naturetin is outstandingly effective not only in establishing, but also in maintaining, excretion of retained fluid in edematous patients. And its duration of action is sufficiently prolonged to allow a single daily administration in most patients. Naturetin is also an effective antihypertensive agent.

Contraindications: Severe renal impairment; previous hypersensitivity.

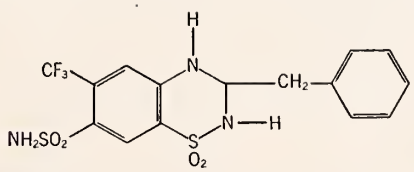
Warning: Ulcerative small bowel lesions have occurred with potassium-containing thiazide preparations or with enteric-coated potassium salts supplementally. Stop medication if abdominal pain, distension, nausea, vomiting, or G.I. bleeding occur.

Precautions: The dosage of ganglionic blocking agents, veratrum, or hydralazine when used concomitantly must be reduced by at least 50% to avoid orthostatic hypotension. Electrolyte disturbances are possible in cirrhotic or digitalized patients.

Side Effects: Bendroflumethiazide may cause increases in serum uric acid, unmask diabetes, increase glycemia and glycosuria in diabetic patients and may cause hypochloremic alkalosis, hypokalemia; cramps, pruritus, paresthesias, and rashes may occur.

Supplied: Naturetin (Squibb Bendroflumethiazide) 5 mg. and 2.5 mg. tablets. Also available Naturetin c̄ K [Squibb Bendroflumethiazide (5 or 2.5 mg.) with Potassium Chloride (500 mg.)]. For full information, see Product Brief.

References: **1.** Southworth, H.: Proc. Soc. Exper. Biol. & Med. *36*:58, 1937. **2.** Mann, T. and Keilin, D.: Nature *146*:164, 1940. **3.** Pitts, R. F., and Alexander, R. S.: Am. J. Physiol. *144*:239, 1945. **4.** Schwartz, W. B.: New England J. Med. *240*:173, 1949. **5.** Friedberg, C. K., in Moyer, J. H., and Fuchs, M.: Edema Mechanisms and Management, Philadelphia, W. B. Saunders Co., 1960, p. 259. **6.** Cumming, J. R.; Tabachnick, E., and Seelig, M., in Moyer, J. H., and Fuchs, M.: op. cit., p. 254. **7.** Werko, L., in Moyer, J. H., and Fuchs, M.: op. cit., p. 188. **8.** Beyer, K. H., Jr., in Moyer, J. H., and Fuchs, M.: op. cit., p. 274. **9.** Maren, T. H., and Wiley, C. E.: J. Pharmacol. & Exper. Therap. *143*:230, 1964. **10.** Earley, L. E., and Orloff, J.: Ann. Rev. Med. *15*:149, 1964. **11.** Fuchs, M., and Mallin, S. R., in Moyer, J. H., and Fuchs, M.: op. cit., p. 276. **12.** Ford, R. V., in Moyer, J. H., and Fuchs, M.: op. cit., p. 290. **13.** cited in Fuchs, M., and Mallin, S. R. (ref. 11): op. cit., p. 283.



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In a recent 217-patient hospital study,[1] urinary tract infections were treated with a variety of widely prescribed antimicrobial agents including: a sulfonamide (40 patients), chloramphenicol (20 patients), nitrofurantoin (33 patients), nalidixic acid (30 patients), tetracycline (27 patients), colistimethate sodium (22 patients)...and 2 combinations of 5 agents each (45 patients). The 2 combinations were selected to afford maximal theoretical antibacterial coverage against the usual urinary pathogens. They were (1) tetracycline, chloramphenicol, nitrofurantoin, ristocetin and polymyxin B; and (2) tetracycline, chloramphenicol, erythromycin, nitrofurantoin and colistimethate sodium.

This clinical study shows that the two combinations of antibiotics were not superior to some of their single components. The authors point out that antibiotic antagonism often negates theoretical advantages of multiple therapy. Coly-Mycin Injectable (colistimethate sodium) was one of the single components that was shown to be equal to the combinations and eradicated bacteriuria in two-thirds of the patients.

Theoretical choice of multiple antibacterial therapy has been shown to be no more effective than one well-chosen agent which also offers least patient exposure to possible side reactions, toxicities, allergic manifestations and higher drug costs.

1. McCabe, W. R., and Jackson, G. G.: New England J. Med. 272:1037, 1965.

in gram-negative urinary tract infections often the single well-chosen agent

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Adverse Reactions: Occasional reactions such as circumoral paresthesias, tingling of the extremities, pruritus, vertigo or dizziness may occur. Reduction of dosage may alleviate symptoms. Therapy need not be discontinued, but such patients should be observed with extra care.

Warning: Patients should be cautioned not to drive vehicles or use hazardous machinery while on therapy.

Precautions: In cases of impaired or suspected renal impairment, use with greater caution and reduce dosage in proportion to extent of impairment. Transient elevations of BUN have been reported. As a routine precaution, appropriate blood studies should, therefore, be made during prolonged therapy.

As with all polypeptides, the possibility of muscular weakness, including apnea, due to inadvertent overdosage or normal dosage in the presence of impaired renal function, should not be overlooked. In cases of apnea, medication should be promptly discontinued and assisted respiration given until serum levels fall and normal breathing is restored.

Other antibiotics, such as kanamycin, streptomycin, dihydrostreptomycin, polymyxin, and neomycin, may also have varying neurotoxic or nephrotoxic potential. They should be used with great caution concomitantly with Coly-Mycin Injectable (colistimethate sodium).

For deep intramuscular injection only.

Dosage: By the I.M. route only, in 2 to 4 divided doses ranging from 1.5 to 5 mg./Kg./day (0.7 mg. to 2.3 mg./lb./day). Average adult dose is 2.5 mg./Kg./day (1.1 mg./lb./day). In the presence of bacteremia, septicemia, or other serious infection, greater than average doses may be required; however, maximum daily doses should not exceed 5 mg./Kg. (2.3 mg./lb.) where renal function is normal.

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The Front Line of Medicine

(A Report on a Preceptorship)

JOHN BOYD KAY
Indianapolis*

ON July 23, 1966, I completed a preceptorship with Dr. M. O. Scamahorn of Pittsboro, Indiana. Those six weeks were probably the greatest and most rewarding of my medical school career. The experience has solidified my lifelong desire that I might be a family physician and has given me many ideas about how to practice with intelligent efficiency. I learned about the office practice of medicine which, understandably, cannot be taught at Indiana University School of Medicine.

I was exposed to a multitude of ailments and diseases from functional complaints to severe organic problems. Some of the cases, which I recorded in my diary, I will relate just to prove that the general practitioner sees and treats many interesting as well as routine problems, a few of which are listed as follows: the young lad with idiopathic thrombocytopenia purpura post-rubeola; the hypoglycemic farmer who had always kept candy with him to ward off attacks; the dislocated and sprained shoulders; the post-traumatic deltoid muscle atrophies; four fractured fifth metatarsals; a sprinkling of psychotic and many more neurotic patients; the children in for routine immunizations; the school and camp physicals; the obese climbing up on the "liar's platform"; the kiddies screaming as we put in or took out skin sutures; the same kiddies smiling through tear-stained faces as we gave them "Bravery Rewards" (ice cream certificates) and bubble gum; the repeated admonitions to rest, to soak, to relax, to leave well enough alone . . . ; the E.N.T. work, chiefly removal of ear wax; the unending six-weeks check-ups for new mothers and their infants; the depressed; the colds and poison ivy; the old guys with genuine disc syndromes; the warts; the patients presenting with a multitude of exotic heart murmurs to delight my imagination and strain my powers of auscultation; the two young men who had, as Dr. Scamahorn stated, "played willingly but unwisely" and presented themselves with urethral discharges which on direct smear proved to be gonorrhea; the house calls on stroke, cardiac and arthritic patients; the nervous young man recuperating from Reiter's syndrome; plaster of Paris casting and cast cutting; the detail men; the finances; the . . . this was the routine of the office practice.

Familial Fraternization

These were the people we treated — Mamma, Papa, Grandpa, Grandma, Auntie, and Uncle, to say nothing of the children. Sometimes we would have three generations in one examining room, all being seen at the same time. After all, what is family practice if you do not treat families? Disadvantages of lack of privacy afforded by a one-to-one relationship are far outweighed by the knowledge of the patient gained by knowing him in his family environment. Family practice mixes the routine with the unusual. Never knowing what the next day would bring was the rule, never knowing whether it would produce back and belly aches or diagnostic problems to challenge the most acute medical mind.

I saw in action a practice geared for the care of the acute medical needs of a suburban-rural community. I helped a physician diagnose, treat and follow-up in the management of his patients. Speaking of follow-up, this was probably one of the finer attributes of my experience. I watched the progression of disease in the home, in the office, and in the hospital from time of diagnosis to time of remission.

Disciplined Diagnostician

My place and purpose in Dr. Scamahorn's office was bifold — to learn the art as well as the science of medicine and, more importantly, to observe how he, as one man, manages the general practice of medicine. Both objectives were achieved. I think I could have been with no finer physician, one so well-versed in medical knowledge or one with such a highly efficient and organized practice. I learned that if one is to have a successful practice he must do that which he knows best, i.e., to practice the very best medicine he knows and to discipline himself to his work. Time is the most important commodity and must be well used.

House calls and drug dispensing are integral parts of Dr. Scamahorn's practice, which may sound strange to some in this day and age of drug stores and automobiles. To me this has to be part of family practice, especially in the type of community in which my preceptor is located.

Hendricks County Hospital, in which Dr. Scamahorn practices, is an efficient 88-bed modern hospital which is adequate in nearly every way. I made acquaintances with all 15 of the staff members and participated in their monthly meetings. I also helped in the care of Dr. Scamahorn's hospitalized patients, scrubbed as first assistant to the surgeon in all his surgery, and delivered four babies, using forceps twice.

In regard to medical education, my experience was unsurpassable. Besides what I learned in the home, office, and hospital, I also had opportunity to visit the American Medical Association Convention in Chicago. My wife and I are deeply indebted to the Scamahorns for giving us this experience. I now more fully realize the value, both educational and political, of the major medical conventions and am firmly convinced that continued reading and at least yearly participation are essential to keep abreast of medical knowledge.

My wife's experience with Mrs. Scamahorn was revealing to her, to say the least, in that she had opportunity to observe the vital role played by the physician's wife in running a general practice in a small community.

In conclusion, the preceptorship affirmed and affixed in my mind the continuing need for the true family physician and my desire to be one. It further substantiated my claim that I enjoy all phases of medical practice, but none so thoroughly that I would be happy practicing it alone. In spite of long hours, personal sacrifice and hard work, this is where I belong — on the front lines of American medicine with its routine, its unusual, its joys, its hardships and its rewards. ◄

*Senior medical student, Indiana University School of Medicine, Indianapolis.

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NORTHERN INDIANA PSYCHIATRIC SOCIETY
Date Fourth Wednesday of every month, September through June
Place For location and program, inquire Beatty Memorial Hospital, Westville

INDIANA NEUROPSYCHIATRIC ASSOCIATION
Date Second Wednesday of the month, October through May, excluding December
Place The Athenaeum, Indianapolis

AMERICAN COLLEGE OF SURGEONS, INDIANA CHAPTER
Date April 7-8, 1967
Place Morris Inn, Notre Dame University, South Bend

INDIANA ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY
Date May 4-6, 1967
Place Stouffer Inn, Indianapolis

INDIANA PHARMACEUTICAL ASSOCIATION
Date July 18-20, 1967
Place French Lick Sheraton Hotel, French Lick

INDIANA ACADEMY OF GENERAL PRACTICE
Date May 3-4, 1967
Place Murat Temple, Indianapolis

INDIANA STATE MEDICAL ASSOCIATION CONVENTION
Date October 9-12, 1967
Place Indianapolis

INDIANA PUBLIC HEALTH ASSOCIATION
Date April 26-27, 1967
Place Indianapolis

INDIANA STATE ASSOCIATION OF MEDICAL ASSISTANTS
Date April 28-30, 1967
Place Van Orman-Roberts Hotel, Muncie

INDIANA ROENTGEN SOCIETY
Date May 7, 1967
Place Indianapolis

Plan to Attend

January 22-23, 1967
Palmer House
Chicago, Illinois

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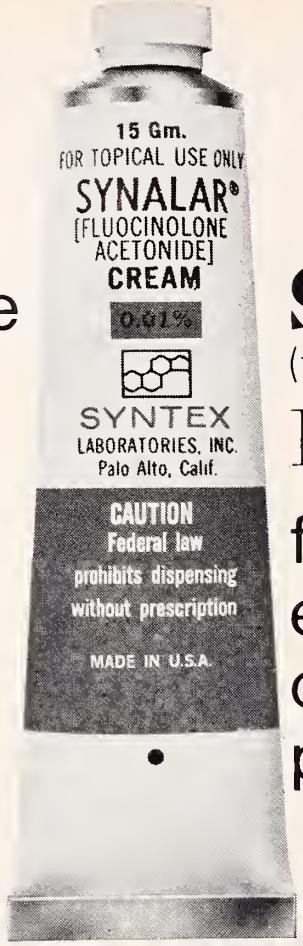

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Contraindications: Tuberculous, fungal, and most viral lesions of the skin (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of its components. **Precautions:** 1. *General*—Synalar Cream 0.01% is virtually nonsensitizing and nonirritating. Where severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. 2. *Occlusive dressing method*—With occlusion of extensive areas, systemic absorption of the corticosteroid may occur, and suitable precautions should be taken. Occasional patients may show contact sensitivity to a particular dressing material or adhesive. Miliaria, folliculitis, or pyodermas have been seen infrequently with the use of this technique. The development of infection requires appropriate antibacterial therapy and discontinuation of the occlusive dressing method. Local atrophy and striae have been reported with protracted occlusive dressing therapy. While lesion relapses can be expected to occur in many psoriatic patients, remissions may persist for several weeks to several months in favorable cases. The patient whose psoriasis is in an active stage, with recent appearance of new lesions, may not be a good candidate and may show early relapse. Some plastic films may be flammable, and due care should be exercised in their use. Similarly, caution should be employed when such films are used on or left near children to avoid the possibility of accidental suffocation. **Side Effects:** Side effects are not ordinarily encountered with topically applied corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. **References:** 1. Cahn, M. M., and Levy, E. J.: J New Drugs 1:262 (Nov.-Dec.) 1961. 2. Meenan, F. O.: J Irish Med Ass 52:75 (Mar.) 1963. 3. Robinson, H. M., Jr., Raskin, J., and Dunseath, W. J. R.: Southern Med J 56:797 (Jul.) 1963.

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Co-ordination of Benefits

(One of a series prepared by Blue Cross-Blue Shield)

A "Co-ordination of Benefits" clause has been included in many of our master contracts to provide a contractual agreement with the employer to avoid the duplication of benefits. This clause provides that payment made under the Blue Cross-Blue Shield master contract and one or more other health care insurance programs shall not result in a total payment in excess of the total expenses incurred by the patient.

The co-ordination of benefits idea was first established by a few of the commercial health insurance carriers. Today most of the private health insurance companies have included this provision in their group contracts. In order for Blue Cross-Blue Shield to remain competitive and to prevent the inefficient use of health care dollars, it has been necessary for us to develop the same type of program for use as necessary.

Many of our accounts realized the financial meaning of this situation, and told us they had to have a "Co-ordination of Benefits" clause in their contract with us. They realized that the lack of such a clause increased our costs and membership fees.

Over the years health care coverage has been expanded to the point that today's typical group contract provides comprehensive coverage and covers most of the expense of illness or accident costs. When a husband has family protection at one place of employment, and the wife has family protection at another place of employment, or they have double or triple protection on some other basis, the resulting payments more than pay the cost of the illness.

Therefore, millions of dollars are being diverted each year to excessive payments to members of two or more "group" plans, and those involved often make a sizeable profit from an illness by collecting from more than one insurer. Such duplication of benefits is a factor in necessary increases in membership fees and premiums for both our members and those insured by private health insurance companies. Several surveys made by other plans and private companies indicate that duplicate coverage increases costs an average of three percent.

Under our "Co-ordination of Benefits" program, the plan which is obligated to pay its benefits first is known as the "primary carrier," and the plan which is obligated to pay additional benefits not paid by the "primary carrier" is known as the "secondary carrier." The responsibility for payment of benefits follows this order: (a) The plan covering the patient as an employee is the "primary carrier" and is obligated to pay before the plan covering the patient as a dependent; (b) The plan covering the patient as a dependent of a male employee is the "primary carrier" and is obligated to pay before the plan covering the patient as a dependent of a female employee; (c) When the order of payment cannot be determined by "a" or "b", the "primary carrier" will be the one which has covered the patient for the longer period of time. Blue Cross and/or Blue Shield is considered the "secondary carrier" when the other plan does not contain a "Co-ordination of Benefits" provision.

The use of "Co-ordination of Benefits" does have an effect upon the time required for Blue Shield to process and pay this type of claim. It is now necessary to determine if the patient has other group health insurance coverage. If the patient does have other coverage, Blue Shield must then contact the other carrier to ascertain what amounts will be paid and by whom. This additional procedure means that some claims may be delayed longer than our normal processing time. The length of time for the delay does not depend directly on Blue Shield, but on the time required by the patient and possibly the other insurance carrier to answer our inquiry. Some added time is necessary in processing "Co-ordination of Benefits" claims, but we are doing everything we can to process claims of this type as rapidly as possible. ◄

W. C. Huddlestone
Communications Division

INDIANA STATE BOARD OF HEALTH

MONTHLY REPORT—September, 1966

Disease	Sept. 1966	Aug. 1966	July 1966	Sept. 1965	Sept. 1964
Animal Bites	931	1038	967	1144	799
Chickenpox	45	53	75	46	26
Conjunctivitis	62	158	85	105	96
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	54	44	44	116	47
Gonorrhea	501	474	338	345	361
Impetigo	214	221	130	262	184
Infectious Hepatitis	41	21	30	42	35
Infectious Mononucleosis	46	31	45	63	32
Influenza	280	137	112	543	299
Measles (Rubeola-Rubella)	74	94	322	86	96
Meningitis, Meningococcal	5	7	1	2	5
Meningitis, Other	9	4	4	2	11
Mumps	53	59	81	58	96
Pertussis (Whooping Cough)	17	23	32	17	40
Pneumonia	86	136	153	260	152
Poliomyelitis	0	0	0	0	4
Streptococcal Infection	312	265	238	549	395
Syphilis					
Primary & Secondary	7	13	9	5	6
All Other Syphilis	101	94	86	97	94
Tinea Capitis	3	12	5	21	4
Tuberculosis (Active)	88	83	83	82	89

★

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WANTED: Locations Physicians

GENERAL PRACTICE

Francisco S. Pareja, 1326 Woodview Ave., Calumet City, Ill.—*group or associate*

Ernest M. Comacho, 306 E. Edgewater St., Camtria, Wis.—*group or associate*

Claudio M. Contreras, 1150 E. Court St., 1-A, Kankakee, Ill. 60901

Ronald G. Chism, U. S. S. Providence CLG-6, FPO San Francisco, Calif. 96601

Alfredo Q. Paje, P. O. Box 1084, Murdochville, Quebec, Canada

Senen J. Encinas, 355 Glen Oaks Dr., Cincinnati, Ohio 45238

SPECIALISTS

Eugenio N. Tan, 427 Rizal St., Angeles City, Philippines—*Anesthesiology*

Byong Gak Min, 23312 Masonic Blvd., St. Clair Shores, Mich. 48082—*Internal Medicine*

Donald D. Davis, 49 Wellington Rd., Ardmore, Pa. 19003—*Neurosurgery*

R. Farag, 413 Wood Ave., Cincinnati, Ohio —*General Surgery*

Charles R. Henry, Bryn Mawr Hospital, Bryn Mawr, Pa.—*General Surgery*

Lewis E. Jolly, 722 W. Main St., Madison, Ind. 47250—*General Surgery*

Ramachandra Kurup, 1750 W. 28. Cleveland, Ohio 44113—*General Surgery*

Hooshang Kadivar, U. T. Memorial Hospital, Knoxville, Tenn. 37912—*General Surgery*

Robert J. Russell, 2068 Yorktown Dr., Ann Arbor, Mich. 48105—*General Surgery*

John R. Ibach, Jr., 162 Hunting Hills Lane, Media, Pa. 19063—*General Surgery*

George N. Riffle, 256 S. Alder St., Philadelphia, Pa., 19107—*Urology*

Harold A. Just, 201 Wickham Way, Norwood, Mass. 02062—*Urology*

Ceferino S. Quizon, 2424 East 73rd St., Chicago, Ill. 60649—*position with Department of Health, Tuberculosis Control*

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How to Disserve the Public

No one can deny that the provisions of the Federal Food, Drug and Cosmetic Act and its amendments are in the public interest and promote drug safety to a degree not surpassed anywhere in the world. But it must be recognized — and this I cannot stress too strongly — that the provisions of these drastic and far reaching amendments should be administered in a scientific and flexible manner.

An overly strict interpretation and application of the legal and regulatory language of the recent amendments could stifle the development and production of new drugs. To regulate the production and use of drugs by responding to pressure groups and to the whim and fancy of biased and overly critical individuals whether lay or scientific, would be a disservice to the public. — Joseph F. Sadusk, Jr., M.D., to American College of Physicians, New York, April 19, 1966.

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The patient suffering from head cold congestion, for instance, should breathe easier when you prescribe Novahistine LP.

Novahistine LP is a long-acting decongestant that helps restore normal mucus secretion and ciliary activity—physiologic mechanisms which prevent infection of the respiratory tract. Two tablets in the morning and two in the evening will provide around-the-clock relief by helping to keep congested air passages clear, thus enabling your cold patient to enjoy normal and free breathing.

Use cautiously in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Tell patients who operate machinery or motor vehicles that drowsiness may result.

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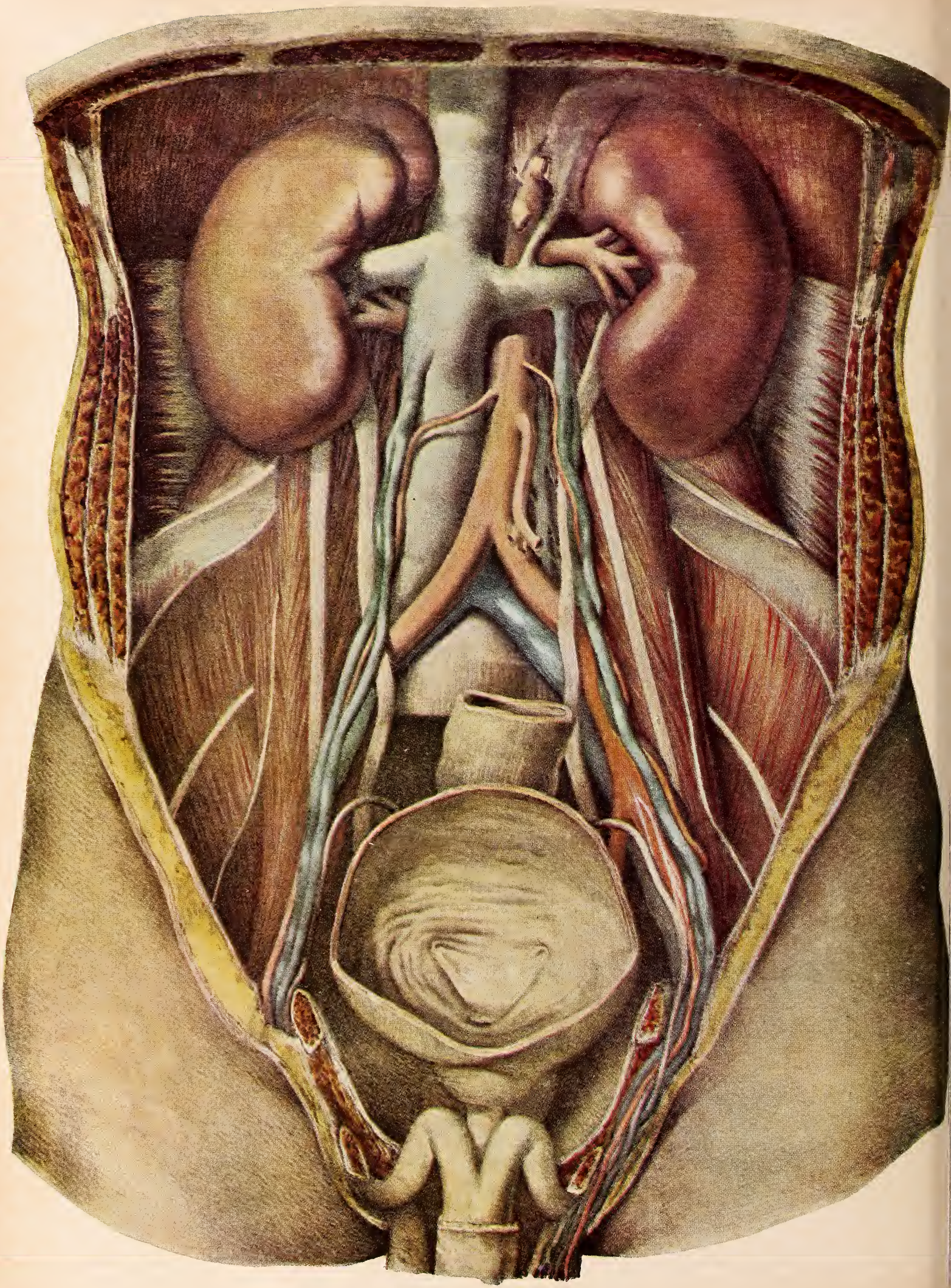

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Normally produces high and persistent levels in blood and high concentrations in bile and urine.

Significant inherent stability.

**Exclusive of penicillinase-producing bacteria.*

Indications: Urinary tract infections, especially those caused by *E. coli*, *Proteus mirabilis*, and *Streptococcus faecalis* and *viridans;* respiratory infections caused by *H. influenzae*, pneumococci, streptococci, and nonpenicillinase-producing staphylococci; and gastrointestinal infections caused by *Shigella* and *Salmonella*, including *Sal. typhosa*.

Contraindications: Hypersensitivity to penicillin; infections due to penicillinase-producing staphylococci and other penicillinase-producing bacteria.

Precautions: If allergic reaction occurs, discontinue ampicillin and administer epinephrine, corticosteroids, antihistamines and/or pressor amines as indicated. Transient moderate elevation of SGOT values of undetermined significance was noted in a few infants. Liver and kidney function as well as hematopoietic tests are advisable during therapy, particularly in infants. As with other antibiotics, precautions should be taken against gastrointestinal superinfection. Safety for use in pregnancy has not been established.

Adverse Reactions: Occasional mild side effects as urticaria, skin rash, pruritus, diarrhea, nausea and vomiting. There have been no reports of blood dyscrasias, liver or kidney damage. Anaphylaxis has been reported.

Composition: Capsules, 250 mg.

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Contraindications: Dextra-amphetamine sulfate: in hyperexcitability and in agitated prepsychatic states. Previaus allergic ar idiasyncratic reactians ta meprabamate.

Precautions: Use with cautian in patients hypersensitive to sympathamimetic campaunds, who have coronary ar cardiavascular disease, ar are severely hypertensive.

Dextra-amphetamine sulfate: Excessive use by unstable individuals may result in psychalagical dependence.

Meprabamate: Careful supervisian af dase and amaunts prescribed is advised, especially far patients with knawn prapensity far taking excessive quantities af drugs. Excessive and pralanged use in susceptible persans, e.g. alcaholics, farmer addicts, and ather severe psychaneuratics, has been reparted ta result in dependence an the drug. Where excessive dasage has cantinued far weeks ar manths, reduce dasage gradually. Sudden withdrawal may precipitate recurrence af preexisting symptoms such as anxiety, anorexia, ar insamnia; ar withdrawal reactians such as vamiting, ataxia, tremars, muscle twitching and, rarely, epileptifarm seizures. Shauld meprabamate cause drawsiness ar visual disturbances, reduce dosage and avaid aperatian af matar vehicles, machinery ar ather activity requiring alertness. Effects af excessive alcahal consumptian may be increased by meprabamate. Apprapriate caution is recammended with patients prane ta excessive drinking. In patients prane ta both petit and grand mal epilepsy meprabamate may precipitate grand mal attacks. Prescribe cautiausly and in small quantities ta patients with suicidal tendencies.

Side Effects: Overstimulatian af the central nervaus system, jitteriness and insamnia ar drawsiness.

Dextro-amphetamine sulfate: Insamnia, excitability, and increased matar activity are camman and ardinarily mild side effects. Canfusian, anxiety, aggressiveness, increased libida, and hallucinatians have alsa been abserved, especially in mentally ill patients. Rebaund fatigue and depressian may fallaw central stimulatian. Other effects may include dry mauth, anarexia, nausea, vamiting, diarrhea, and increased cardiavascular reactivity.

Meprabamate: Drawsiness may accur and can be associated with ataxia; the symptam can usually be cantralled by decreasing the dase, ar by cancamitant administratian af central stimulants. Allergic ar idiosyncratic reactians: maculapapular rash, acute nanthrambacytapenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case af fatal bullaus dermatitis, fallawing administratian af meprabamate and prednisalane, has been reparted. Hypersensitivity has praduced fever, fainting spells, angianeuratic edema, branchial spasms, hypatensive crises (1 fatal case), anuria, stamatitis, practitis (1 case), anaphylaxis, agranulacytasis and thrambacytapenic purpura, and a fatal instance af aplastic anemia, but anly when ather drugs knawn ta elicit these canditians were given cancamitantly. Fast EEG activity, usually after excessive dasage. Impairment af visual accammadatian. Massive averdasage may praduce drawsiness lethargy, stupar, ataxia, cama, shack, vasamotar and respiratary callapse.

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Medicine At Law

DECISIONS AND OPINIONS

Highlights of recent court actions pertaining to health and medicine from *The Citation* prepared by the Law Division of AMA.

Suit Against Hospital for Brain Damage at Birth Settled for $100,000 — A suit against a hospital for permanent brain damage sustained by a child at birth has been settled for $100,000. The child, who is now eight years old, cannot walk or talk and is incapable of learning. It was claimed that a hospital nurse had delayed the child's birth by pressing a towel against his head until the physician arrived. There was expert testimony that the repressed birth was the cause of his present condition. There were three trials of the suit and, in each of them, the jury held the hospital liable. Each verdict was reversed on appeal on the ground that the evidence as to negligence and causation was insufficient. The damages awarded in the three trials were $187,000, $158,000, and $282,000. (News Release, New York, N. Y., July 14, 1966).

U. S. Supreme Court Holds Blood-Alcohol Test Results Admissible—The results of a chemical test of a sample of a driver's blood, taken over his objection by a physician while he was in the hospital after being arrested, were properly admitted in evidence in a prosecution against him for driving while under the influence of intoxicating liquor, a five-judge majority of the U. S. Supreme Court ruled.

The driver was taken to the hospital after he was involved in an automobile accident. A police officer came to the hospital and arrested him. The officer asked him to consent to a blood-alcohol test. The driver, on advice of counsel, refused. The officer directed a physician to withdraw a sample of the driver's blood. A chemical test of the sample showed an alcohol concentration indicative of intoxication.

The admission of the test results did not violate the driver's right to due process of law. Under the circumstances of the case, the taking of the sample was not offensive to "a sense of justice."

The taking of the sample over the driver's objection constituted "compulsion." However, the admission of the result of the test made of the sample did not violate the driver's constitutional privilege against self-incrimination. The privilege is a bar only against compelling "communications" or "testimony." The driver's testimonial capacities were not involved in any way. The test results depended solely on the chemical analysis. The test results were neither the driver's testimony nor evidence relating to some communicative act or writing on his part. Thus, the admission of the results did not violate his privilege against self-incrimination.

Nor did the admission of the test results violate the driver's constitutional right to the assistance of counsel. Since he was not entitled to assert his privilege against self-incrimination, he had no greater right because his counsel erroneously advised him that he could do so.

The taking of the sample was a "search" of the driver's body. The driver was under arrest when the sample was taken. The arrest was a lawful one, even though it was made without a warrant. On the basis of his examination of the accident scene and his observation of the driver, the officer had probable cause for believing that he had committed an offense. The "search" was reasonable, even though the officer did not have a search warrant. The officer could reasonably have believed that the evidence would have disappeared during the delay necessary to obtain a search warrant. Two hours had elapsed since the accident, and alcohol in the blood begins to diminish shortly after drinking stops. The amount of blood taken was minimal, and the extraction involved virtually no risk, trauma, or pain. The sample was taken in a reasonable manner. It was taken by a physician in a hospital according to accepted medical practices. Therefore, there was no violation of the driver's constitutional right to be free from unreasonable search and seizure.

Schmerber v. State of California, 86 S. Ct. 1826 (U. S., June 20, 1966).

Cross-Examination of Physician on Basis of Medical Text Properly Disallowed — In a suit for damages for a whiplash injury sustained in an automobile accident, a trial court did not err in refusing to permit the physician who had treated the injury to be cross-examined on the basis of an article written by an authority on such injuries, the Arkansas Supreme Court ruled. A physician may be cross-examined concerning a recognized medical test with which he is familiar. The

physician stated that he had not read and knew nothing about the article on which the cross-examination was to be based.

Ward v. Lamb, 402 S.W.2d 675 (Ark., May 16, 1966).

Insured Recovers Disability Benefits Following Traumatic Loss of Remaining Eye — An insured who lost the vision in his remaining eye as the result of a fall was entitled to benefits for total disability caused directly and exclusively by accidental means, even though the earlier loss of his other eye had been caused by disease, an Ohio intermediate appellate court ruled.

The insured had lost the vision in his left eye several years before as the result of glaucoma, but had continued to work as a bookkeeper. After the fall, he was found to have a detached retina of the right eye, and surgery was performed. The insured's vision was so limited after the operation that he had to give up his job. The insured suffered from glaucoma in his right eye at the time of the fall. There was no evidence that the loss of vision of the right eye was caused by anything other than the fall.

The insurer contended that a person sees by means of two eyes and, since the loss of vision in the insured's left eye was caused by disease, he could not recover under the policy no matter what happened to his right eye, even though he had continued to work until he lost the vision in his right eye. The insurer, if it had wished to do so, could have provided that where one of two bodily functions is destroyed by disease, there could be no recovery under the policy for the loss of the other. It did not do so. The loss of vision which rendered the insured totally disabled resulted from the fall.

Garrigan v. Fidelity & Casualty Co. of New York, 216 N.E. 2d 891 (N. Y., May 18, 1966).

Woman's Right of Privacy Not Violated by Physician's Letter Stating She Was Mentally Ill — A suit for damages by a woman against a physician for allegedly having violated her right to privacy, by having sent a letter to the Counselor in Mental Health of the county psychiatric department stating that she was mentally ill, was properly dismissed on the ground that it failed to state a cause of action, a California intermediate appellate court ruled.

The physician, who was not the woman's physician, sent the letter after a short encounter with her in a parking lot. The nature of the encounter was not known. The letter was not in the form of a verified petition as required by the statute relating to proceedings to investigate a person's mental health. On the basis of the letter, the Counselor obtained a court order appointing a physician to examine the woman as to her mental health. That physician never examined the woman. The court proceeding was dismissed after the woman's personal physician filed a report.

If the physician had filed a verified petition and had probable cause for believing the woman mentally ill, he would, under the terms of the statute, have been immune from civil or criminal liability. He is entitled to the same immunity even though he did not file a verified petition. Since the woman did not allege in her complaint that the physician acted without probable cause, it must be assumed that he had probable cause for his act, the court said. The letter was a good faith communication to a law enforcement agency of information on which it could conduct an investigation, and was, therefore, not a violation of the woman's right of privacy. There was no publication of the physician's letter such as is required to give rise to a cause of action for the invasion of privacy.

Schwartz v. Thiele, 51 Cal. Rptr. 767 (Cal., June 14, 1966).

Child Held "Neglected" on Basis of "Battered Child Syndrome" — The evidence of a child's injuries, for which her parents could offer no satisfactory explanation, established the "battered child syndrome" which required a finding that the child was "neglected" within the meaning of the Family Court Act, a New York trial court ruled.

In a child neglect proceeding based on a claimed "battered child syndrome," the person instituting the proceeding has the burden of proving the claim by a preponderance of the relevant, competent, and material evidence. When the person instituting the proceeding has shown that the child has sustained substantial injuries while in its parents' custody, he is deemed to have established a prima facie case. The burden of proof then shifts to the parents who are then required to present a satisfactory explanation concerning the injuries.

The person bringing the proceeding established that the child's body and arms were covered with bruises, that she had a deep abrasion on the bridge of her nose and a severe scalp laceration, and that her arm had been broken. All of the injuries had been sustained within a period of two months. Medical experts testified that the pattern of injuries was such that they could not have resulted from a single fall. They also testified that the fracture of the arm was such that it could not possibly have been caused in the manner testified to by the child's mother.

It might be that no single one of the injuries, considered by itself, could be regarded as evidence of neglect. However, when all of the injuries were considered together, their cumulative effect compelled a finding that the parents had, to the child's substantial injury, neglected the duties they owed her, and that she was "neglected" within the meaning of the Family Court Act. This conclusion was strengthened by the fact that there were important inconsistencies in the evidence presented by the parents.

In re Young, 270 N. Y. S. 2d 250 (N. Y., May 20, 1966).

Blood Transfusion Ordered Over Patient's Religious Objections — A hos-

pital outpatient, a Jehovah's Witness, who refused to consent to a blood transfusion on the ground that it was contrary to her religious beliefs, was ordered to submit to a transfusion in order to save the life of her unborn child. The transfusion was ordered by a Pennsylvania trial court.

A physician testified that the transfusion was necessary because of an Rh incompatibility. He stated that a direct transfusion of red blood cells before birth was necessary, and that the danger involved was very slight. He said that without the transfusion the baby's chances of survival were "almost zero," and of its survival without brain damage were "less than zero."

Although the patient had refused to consent to the transfusion, she said she would comply with a court order. She had, before the transfusion was ordered, signed a waiver releasing the hospital of any responsibility for anything that might happen if a transfusion was not given. (News Release, Philadelphia, Pennsylvania, July 13, 1966).

Hospital Liable for Patient's Burns From Fire in Bed — In a suit for damages against a hospital for burns sustained by a patient when his bed caught on fire, the evidence was sufficient to support the jury's verdict in favor of the patient, a Georgia intermediate appellate court ruled.

The patient was paralyzed and had a vocal impairment. The hospital knew that the patient had a pipe in his room and that he smoked it. One attendant testified that the morning of the day on which the fire occurred, the patient had smoked the pipe while a visitor was with him. He said that he took the pipe from the patient when the visitor left and put it on a table out of the patient's reach. There was testimony that attendants had been in the patient's room 5 to 10 minutes before the fire was discovered, and that there was nobody with the patient then. There was no evidence that anyone other than attendants had been in the patient's room after the morning visitor left. The patient's pipe and matches were found on the floor after the fire. In view of the patient's known condition, leaving him unattended with a lighted pipe would constitute negligence. The jury could reasonably infer from the evidence that an attendant had given the patient his pipe, lighted it, and then left him unattended.

There was a sufficient showing of exclusive control by the hospital of the pipe and matches, the instrumentality that caused the fire, to make the doctrine of res ipsa loquitur applicable. The hospital should reasonably have foreseen the danger of leaving the patient unattended while he was smoking his pipe. The hospital had the duty of controlling the object presenting the possibility of harm. The evidence established that the hospital had the opportunity to control the pipe and matches. Res ipsa loquitur was applicable even though it was not shown that hospital employees were the only possible ones who could have left the pipe in the patient's mouth. There was no evidence at all that any hospital visitors had been in his room after attendants had been there a short time before the fire was discovered.

The trial court did not err in refusing to instruct the jury on contributory negligence. There was no evidence as to the identity of the person who gave the patient the lighted pipe and left him unattended or that the patient accepted the pipe with the knowledge that he would be left unattended. It must be inferred that the patient accepted the pipe with the belief that he would not be left unattended. The evidence clearly established that the patient was physically unable to get the pipe from the table where it was kept and light it for himself.

Hospital Authority of City of St. Mary's v. Eason, 148 S.E. 2d 499 (Ga., March 30, 1966).

Physicians Required, On Pretrial Discovery, To Answer Questions Calling For Expert Opinion — Two physicians against whom a suit for damages had been brought by a patient who, following an appendectomy, developed peritonitis as the result of a fecal fistula, were required, in a pretrial discovery proceeding, to answer even those questions which called for an expression of expert opinion, a New Jersey intermediate appellate court ruled.

The issue here was not whether a physician against whom a suit for professional negligence has been brought can be called at the trial, under the adverse witness statute, by the patient and be required to answer questions calling for an expression of expert opinion. This was a pretrial discovery proceeding. The purpose of a pretrial discovery proceeding is to provide the parties with avenues of inquiry before the trial in order that substantial justice may be achieved. Pretrial discovery extends to a physician's opinion and exercise of judgment in the course of treating his patient, and he can be required to explain why he did or did not do certain acts. His findings, the actual course of treatment, his diagnoses, and his opinions as to the proper course of treatment are legitimate subjects of inquiry. The opinions expressed must, of course, relate to the treatment of the particular patient.

Rogotzki v. Schept, 219 A.2d 426 (N. J., Apr. 28, 1966).

Jury's Findings On Special Issues of Proximate Cause and Damages Not Fatally Inconsistent — In a suit for damages against a physician by a patient in whose vagina a gauze pad was left following a biopsy, the jury's findings on special issues submitted to it on proximate cause and damages were reconcilable, a Texas intermediate appellate court ruled.

The jury found that the physician's negligence in leaving the gauze pad in the patient's vagina was not the cause of any harm to the physical structure of her body. On a second special issue, the jury found that the patient was entitled to damages of $4,000 for the pain, mental anguish, and loss of earnings which proximately resulted from

the injuries sustained on the occasion that was the basis of the suit. The jury had been instructed that it could allow damages to the patient for any aggravation that leaving the gauze pad in her vagina caused to a condition of her body that existed before the biopsy was performed. It would assume that the jury awarded damages because it found that the patient's preexisting condition had been aggravated, the court said. On the basis of that assumption, the jury's findings on proximate cause and damages could be reconciled.

Dobbins v. Gardner, 402 S.W. 2d 804 (Tex., April 14, 1966; rehearing denied, May 19, 1966).

Physician's Property Liability Insurer Required To Defend Him In Patient's Suit For Fall — The property liability insurer of a physician was required, under its policy, to give him a complete defense in a damage suit pending against him by a patient for injuries sustained when he fell in the physician's office, a federal trial court ruled.

While the patient, a polio victim, was in the treatment room, the physician took his crutches from him and helped him from a chair to a stool. The patient fell to the floor and was injured when his shifting of his position on the stool caused it to slide out from under him.

The insurer contended that it had no duty to defend the physician in the patient's suit because the policy excluded coverage for "injury, sickness, disease, death, or destruction due to the rendering of or the failure to render any professional service." There was a "gray area" at the policy's fringes where a given accident may be considered as the result of either the ordinary negligence of a property owner or of the improper rendering of or failure to render professional services, the court said. There was a possibility that the property liability insurer will be legally obligated to reimburse the physician for a judgment rendered against him in the patient's suit. Therefore, it must give him a complete and unqualified defense in that suit.

By a third-party complaint, the property liability insurer sought a declaration that only the physician's professional liability insurer was obligated to defend him and to pay any judgment that might be rendered against him in the patient's suit. Since the professional liability insurer is giving the physician a full defense in the patient's suit, and there is no indication that it will not continue to do so and pay any judgment against him that it is legally obligated to pay, the third-party complaint was completely premature and conjectural.

Hazard v. Aetna Casualty and Surety Company, 253 F. Supp. 845 (D. C., D. of C., April 28, 1966).

Physician Not Liable For Patient's Paralysis Following Injections — Damages could not be recovered in a suit against a physician by a patient whose left leg became paralyzed allegedly as the result of the negligent administration of hypodermic injections in connection with his performance of a tonsillectomy and adenoidectomy, the Connecticut Supreme Court ruled.

As part of the patient's preoperative and postoperative care ordered by the physician, nurses gave her an injection in her left buttock on three occasions. It was claimed that the paralysis was caused by the hypodermic needle's penetration in or about the sciatic nerve during one of the injections.

The physician could not be held liable under the doctrine of respondeat superior for any negligence on the nurses' part in giving the injections. They were not in his employ and he did not supplant the hospital as their master by exercising control and supervision over them while they gave the injections. He could not be held liable under the borrowed servant rule because there was no evidence that they were temporarily loaned to him while they were giving the injections.

The physician could not be held liable on the theory that the nurses' alleged negligence constituted a breach of his contract with the patient's mother. She testified that the physician had agreed to have the patient admitted to the hospital, to take care of everything, and to see that whatever was necessary was done. The question was whether the physician, by agreeing to take care of everything and to see that whatever was necessary was done, personally guaranteed that nothing unexpected or unusual would result from the injections, which were presumably things that were necessary to be done. To so interpret the contract would violate the rule that a promise not expressly made will not be read into a contract unless it arises by necessary implication from the contract's terms. It could be assumed that neither the physician nor the patient's mother anticipated her paralysis. However, the case was submitted to the jury on the basis of a claimed breach of an express contract, and the jury's verdict in favor of the patient could be justified only by adding a provision that could not reasonably have been within the intention of the parties. The construction and legal effect of the contract was a question of law for the trial court, and it should have directed a verdict for the physician, the court said.

Bria v. St. Joseph's Hospital, 220 A. 2d 29 (Conn., Apr. 29, 1966).

Insured Not Entitled to "House Confinement" Benefits — An insured was not entitled to recover "house confinement" benefits in a suit against his health and accident insurer, where the evidence showed merely that he was physically unable to perform the manual labor required by his occupation of farming, the Court of Appeals of Tennessee ruled.

The insured suffered from hypertension, diabetes and a peptic ulcer. The insured's physician testified that his condition disabled him from performing manual labor, but that it was not such as to require house confinement or to restrict his activities generally. The fact that the insured spent most of his time in the house or under the shade of trees in the yard was his own choice, and was not required by his physician or his illness. To permit the insured

to recover under these circumstances would be to say that the meaning of a "house confinement" clause was identical with that of a "total disability" clause, the court said.

Mutual Benefit Health and Accident Association v. King, 396 S.W. 2d 94 (Tenn., July 27, 1965; cert. denied, Oct. 18, 1965).

Receipt of Workmen's Compensation Benefits No Bar to Malpractice Suit for Aggravation of Industrial Injury — A suit for damages against two physicians and a hospital by a workmen's compensation claimant for aggravation of his industrial injury by allegedly negligent treatment was not barred by the fact that the claimant was being paid compensation in an amount which included compensation for the injuries allegedly caused by the treatment, the Supreme Judicial Court of Massachusetts ruled.

Under the statute, a claimant has the right to proceed against third parties, and there is nothing in the statute limiting that right to third persons who caused the original injury. The section of the statute providing that the filing of a claim for or the acceptance of compensation benefits releases an employer does not extend the effect or the release to subsequent wrongdoers. It was immaterial that it might be difficult to apportion the compensation payments between the original injury and the aggravating injuries. The claimant's right against third persons are unaffected by compensation benefits. Under the statute, the original injury and all foreseeable consequences are compensable. By claiming compensation, the claimant elects to have only the rights provided by the statute for all compensable consequences of the injury. Whenever malpractice occurs, he has the compensation payments and the additional statutory right to pursue the third parties if the insurer does not do so. The claimant's right to pursue third parties is not defeated by the fact that, in cases where the malpractice occurs a considerable time after the original injury, questions may arise as to the running of limitation periods.

Turner v. Guiliano, 216 N.E. 2d 562 (Mass., May 3, 1966).

Manufacturer Not Liable to Patient Where Drug and Labeling Approved by Food and Drug Administration — A patient who suffered adverse effects after taking MER/29 was not entitled to recover damages in a suit against the manufacturer for breach of warranty, the Oregon Supreme Court ruled. There was sufficient evidence to support the jury's finding that the manufacturer had fully disclosed all known and relevant information as to the drug's safety to the Food and Drug Administration. This amounted to a finding that the drug was not willfully or negligently mislabeled. A drug, properly tested, labeled with appropriate warnings, approved by the FDA, and marketed in accordance with federal regulations is, as a matter of law, a reasonably safe product. A person who claims to have suffered adverse effects from taking such a drug cannot recover against the manufacturer for breach of warranty unless he proves the drug was impure or inadequately labeled. There was no such proof here.

Lewis v. Baker, 413 P. 2d 400 (Ore., April 20, 1966).

Patient Awarded $200,000 in Suit Against Medical Group for Delay in Treating Scoliosis — In a suit against a medical group by a patient for injuries caused by the delay of physicians in the group in treating her scoliosis, the patient was awarded damages of $200,000 by a California jury.

In May, 1958, the patient went to the medical group because she had a prominent right shoulder blade. X-rays were taken and her condition was diagnosed as scoliosis. She then had a curvature of 45 degrees. X-rays were taken by group physicians at intervals during the next year. In May, 1959, the patient consulted a specialist. He concluded that the patient's curvature had progressed to 60 degrees during the year, and recommended treatment by a cast and spinal fusion.

She returned to the group physicians and they applied a cast in July, 1959. The cast was removed after four weeks, and the group physicians gave her no further active treatment. When she returned to the specialist in December, 1959, the curvature had increased to 70 degrees. He treated it by casting and a spinal fusion and obtained a final permanent reduction of 53 degrees curvature.

The specialist testified that the curvature could have been permanently reduced to 20-25 degrees if it had been treated in May, 1958, and to 30-35 degrees if it had been treated in May, 1959. There was testimony that the curvature's progression had caused malformation of the rib cage, change in the shoulder blades' location, partial collapse of the chest which interfered with vital capacity and reduction in height. Also, the July, 1959, cast had caused pressure sores which required plastic surgery.

Hollister v. Permanente Medical Group, Sup. Ct., San Francisco, Docket No. 518311 (Cal., May 25, 1966).

Physician and Hospital not Liable to Patient Who Fainted After Getting Up Against Orders — A patient was not entitled to recover damages in a suit against a physician and a hospital for the breaking off of two middle front teeth when she fainted and fell in a hospital corridor, an Illinois trial court jury ruled. The physician removed tissue from the frenulum under the tongue of the patient, an outpatient, in an operation performed under local anesthesia in the hospital emergency room. Although she was told to stay quiet after the operation, she got up, left the room, and fainted in the corridor. The patient contended that the physician and three hospital attendants who were present in the room were negligent in failing to use proper restraint and postoperative care. The physician and the hospital contended that the patient's own acts were the proximate cause of her injuries.

Hinricks v. West Suburban Hospital, Cir. Ct., Cook County, Docket No. 62 OP 78 (Ill., April 25, 1966). ◄

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CASE CAPSULES

By

ARNOLD LIEBERMAN, M.D., Ph.D.
Consultant in Internal Medicine
New York, New York

With a Foreword by
FRANK B. RAMSEY, M.D.
Editor
Journal of the Indiana State Medical Association

Having read *The Case of the Upright Debauchee*, it is quite unlikely that any reader will put this book aside until he has delved into all thirty-two case capsules to the final *Case of the Barbed Barbiturate*.

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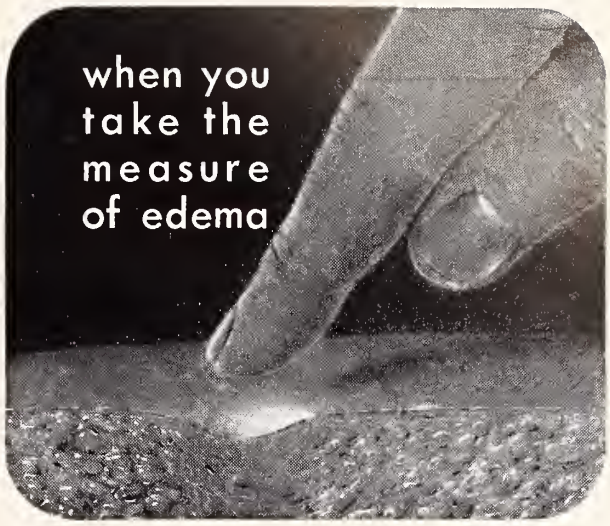

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A synopsis of contemporary psychiatry

George A. Ulett, D. Wells Goodrich, 3rd ed., C. V. Mosby Co., St. Louis, Mo., 1965; 299 pp. with index; $6.75.

Why the title of this little book is entirely in lower case is not clear, unless it is a minor manifestation of oddity in psychiatrists. Be that as it may, this is a down-to-earth condensation of practical psychiatry. As is stated in the preface: "In this text, theory is kept to a minimum . . . . The material is organized into three general areas: (a) history taking and diagnostic procedures; (b) clinical syndromes; and (c) therapeutic measures." This has been done with clarity and the utmost conciseness.

In connection with history taking, there is a chapter on "Psychodynamic concepts of personality development" which is a well conceived presentation of known facts and a few admitted presumptions, illustrating the usual and "normal" progression through life from the cradle to old age, taking note on the way of the commoner variations leading to mental illness later on. Minimal reference is made to *theory*, although this aspect of psychiatry is not neglected. Rather, it is presented always in connection with practical application and interpretation of facts discovered during history taking. This method, of course, emphasizes the prime importance of the history in the subtlest and most effective manner. Defense mechanisms and their role in symptom formation are well described in two laconic pages.

Part Two, "Clinical Syndromes," is introduced by a few words on classification and a table of standard nomenclature. The order (and headings) of the latter is followed in the subsequent discussions of clinical syndromes. Mental retardation and child psychiatry are included.

While advice as to the proper treatment is given with the discussion of each syndrome, there is a third part of the book called "Therapeutic Measures" wherein are descriptions of the psychiatric treatment team and its members together with their functions. After this is found a sort of psychiatric materia medica, well tabulated for quick and easy reference, with columns for name, manufacturer, form, dosage, use, side-effects and precautions, and the names of foreign equivalents.

There are special chapters on management of suicidal patients, civilian disaster, problems in a military setting and forensic psychiatry. The whole work is organized for easy reference and was written for this purpose. In addition, at the end of each chapter, is a list of suggested readings for those needing amplification of the subject.

The chapters on examination of the patient outline both the simple procedures available to and understood by any doctor of medicine, and the more esoteric psychological tests employed by the specialist.

This book should be especially useful to the medical student to help him keep his feet on the ground in the strange land of psychiatry, as well as a reference work for interns and residents. The average practitioner should find it a great aid in keeping up-to-date with trends in psychiatric progress, and in keeping him alert to his own powers and limitations in this field.

There are few errata found, the most noteworthy being on page 66, line 7, where I am sure "parental" instead of "parenteral" is intended.

A. W. CAVINS, M.D.
Terre Haute, Ind.

HERITABLE DISORDERS OF CONNECTIVE TISSUE

Victor A. McKusick, ed. 3, C. V. Mosby Co., St. Louis; 1966; 499 pp., 192 illus., $18.50.

McKusick has been thorough in his attempt to assemble and present current knowledge of the connective tissue disorders which are heritable (transmissible to offspring) even if not inherited in the individual instance.

The first and second chapters are appropriately devoted to general genetic principles and basic biology of connective tissue. The understanding of each is rendered relatively easy by their concise presentation.

This third edition is 150 pages larger than the 1960 second edition with two new chapters having been added which include alkaptonuria and homocystinuria. Bibliography is extensive with references as recent as 1965.

The monograph is clinically oriented with detailed case presentations and excellent illustrations. Each disease is discussed in regard to the history of the disorder, its clinical manifestations, its genetics, its pathogenesis, its prognosis, its pathology and miscellaneous considerations including therapy.

This reviewer finds McKusick's work important reading for the general practitioner, the pediatrician, the internist and the ortho-

pedic surgeon. The work is equally important as a standard reference for nearly all physicians.

HARLEY P. PALMER, M.D.
Indianapolis

TRANSCULTURAL PSYCHIATRY

Ciba Foundation Symposium, edited by A. V. S. De Reuck and Ruth Porter, Little, Brown & Co., Boston, Mass., 1965; 396 pages; illustrated; $12.00.

As the last third of the 20th century opens, 24 distinguished psychiatrists, anthropologists, psychologists and epidemiologists have gathered to take a hard look at *transcultural* psychiatry, i.e., specifically, the scientific comparison of various cultural units as to the etiology and care of mental illness; important conclusions emerge. The cultural background of the patients can give very definite slants to the concrete manifestations of their departures from the accepted norms.

Some of the chapters are outstandingly brilliant. I was particularly impressed by Martha Wolfenstein's discussion re "Changing Patterns of Adolescence." The facts as to the clamor by ever-younger adolescents for sexual prerogatives before the attainment of financial independence make most challenging reading, indeed.

As usual, the binding is good, the editing painstaking and the printing excellent. Most hospital libraries would do well to have this addition to their shelves. Psychiatrists, social workers and allied disciplines should have it as part of their working shelf, also.

ARNOLD LIEBERMAN, M.D.
New York, N. Y.

GIVE AND TAKE — THE BIOLOGY OF TISSUE TRANSPLANTATION

Francis D. Moore, Doubleday & Company, Inc., Garden City, New York, Anchor Books edition, 1965; nine figures and 10 plates; 216 pages; $1.25.

The author is well known for his pioneering developments in tissue transplantation and is more than qualified to write on this subject. As one would expect from an experienced writer, the chapters in this pocket-sized book are well organized and well written. They are written in easily understood common language. The paper and printing are of average quality. The illustrations are generally good. This book is certainly worth more than its actual price. It is to be highly recommended for those who are interested in tissue transplantation.

WEI-PING LOH, M.D.
Gary

TEXTBOOK OF THE PRACTICE OF MEDICINE

Dr. Frederick W. Price, Tenth Ed., under the overall editorship of Ronald B. Scott; 24 co-authors; Oxford University Press, American Office, 16-00 Pollitt Drive, Fairlawn, N. J., 1966; 1259 pages; 18 sections.

It is a pleasure to have the privilege of perusing this freshly updated text. This renowned British product has been becoming obsolescent in the ten years that have elapsed since its previous ninth edition. Dr. Price has died; Dr. Donald Hunter has retired from his editorial post. The first edition appeared in 1922 so that it is fair to compare it with such a work as Cecil's textbook which first saw the light of day in the same decade. Exactly as with Cecil's book, new blood has taken over to give us the magnificent product of 1966.

The authors of the individual sections have been marvelously clear, crisp and practical. The double columns and the legible type make for easy reading. The references with each chapter make a welcome addition. The binding is superb and the paper adequate.

The American reader should learn that a "stone" is 14 lbs; it is abbreviated st.. Hydrallazine (on p. 882) is not really something at which we should cavil. "Haemorrhage" and "oedema" might be archaic spelling but not something to condemn.

All-in-all, this is the equal of any textbook extant and the superior of most. Our English cousins have an excellent style that most of us wish we could emulate. This monograph will be a welcome addition to the library of knowledgeable physicians: from the students up to professors of medicine.

ARNOLD LIEBERMAN, M.D.
New York, N. Y.

NEW SYNDROME OF NEONATAL HYPOGLYCEMIA

J. T. Combs, J. A. Grunt, and I. K. Brandt (Yale University School of Medicine, New Haven)

New Eng. J. Med. 275:236-242, (Aug. 4), 1966.

Three large newborn infants are presented as examples of a hypoglycemic syndrome associated with macroglossia, mild microcephaly, and omphalocele. All had a rather profound and persistent hypoglycemia first manifest on the second or third day of life. Two were significantly polycythemic, and there was a likely element of congestive heart failure in each on this basis. The etiology of this syndrome is obscure. Cortisone, zinc glucagon and diazoxide proved to be helpful adjuncts in the therapy of these patients. One patient had a neutropenia that was ascribed to diazoxide therapy.

URINARY SCREENING TESTS IN THE PREVENTION OF MENTAL DEFICIENCY

T. L. Perry, S. Hansen, and L. MacDougall (University of British Columbia, Vancouver)

Canad. Med. Assoc. J. 95:89-95, (July 16), 1966.

A substantial number of genetically determined biochemical disorders in infants and young children produce mental deficiency and serious illness in early life. Prompt diagnosis of these diseases can lead either to the institution of effective therapy to prevent the development of mental defect, or, where no treatment is presently available, can result in parents being given appropriate genetic counseling, so that they can avoid the birth of further affected children. Eight simple urine screening tests are described which have proved useful in the early detection of metabolic disorders in apparently healthy infants.

COLOR PHOTOGRAPHY WITH A GASTRIC CAMERA AS A COMPLEMENT TO RADIOLOGICAL EXAMINATION OF THE STOMACH

R. N. Gabrielsson (Karolinska Institute, Stockholm)

Nord. Med. 75:739-742, (June 30), 1966.

Color photography of the gastric mucosa as a complement to radiological examination was used with 64 patients. In seven of nine cases of bleeding from the upper gastrointestinal tract, color photography revealed the source of bleeding despite normal radiological findings.

SAFETY OF PHYSICALLY DISABLED DRIVERS

L. Ysander and Lindhs (Gata 4, Goteborg, Sweden)

Brit. J. Industr. Med. 23:173-180, (July), 1966.

Four hundred ninety-four disabled drivers, the majority with loss of function in the legs as the result of poliomyelitis or amputation, were studied with respect to the frequency of traffic accident and serious traffic offenses during a ten-year period. Traffic accidents caused by the drivers' disability occurred in 0.6% of drivers investigated. In all cases the drivers had loss of function in the right leg. A comparison was made between the investigation series and a control series identical as regards sex, age, and license-holding period but with a shorter exposure to traffic than the investigation series. The frequency of traffic accidents was 7.1% in both series and the frequency of serious traffic offense was 2.2% in the disabled, and 14.8% in the controls. Disabled drivers were not an increased hazard in traffic. However, there was greater accident frequency among drivers with loss of function in the right leg or right arm.

SPONTANEOUS DESCENT OF THE TESTICLE

I. J. Cour-Palais, (Westminster Hosp., London)

Lancet 1:1403-1405, (June 25), 1966.

A survey of undescended testicle in 4,580 schoolboys was carried out by medical officers of a local health authority. The incidence of undescended testicle was found to be 2.9%, a figure which agrees closely with a previous similar survey. The 132 boys were subsequently reexamined by a single observer under ideal conditions, and 96 were found to have normal low retractile or high retractile testicles, so that the true incidence of undescended testicle was 0.78%. Since the frequency of undescended testicle at one year is 0.7% and is 0.5% among young adults, it seems that spontaneous descent of the testicle is very rare. Fertility will be impaired or lost if spontaneous descent is awaited too long or after the age of 10 years at the latest.

SEX CHROMATIN ABNORMALITIES IN CARCINOMA OF THE CERVIX UTERI

A. Forni (Sloan-Kettering Institute for Cancer Research, New York) and C. P. Miles

Acta. Cytol. (Balt.) 10:200-204, (June), 1966.

When the sex chromatin was present in cancer cells, it was more often double or larger than in benign cells. Possibly, large and double sex chromatin bodies in cancer smears imply tetraploidy or near tetraploidy. This is also consistent with the tendency for correlation between sex chromatin and nuclear size.

PREVENTION OF VISUAL ACCIDENTS DUE TO CORTISONE

J. Sedan (94, Rue Sylvabelle, Marseille, France)

Ann. Oculist 199:601-611, (June), 1966.

The use of cortisone in rheumatology may cause vascular and tonometric complications as well as lesions of the lens and the cornea. In older persons and in patients with corneal hypoesthesia, ulcers, sometimes with perforation, are frequent, but can be avoided by simultaneous administration of antibiotics. Aureomycin and terramycin were more satisfactory than penicillin in 15 patients tested, as was bismuth per os in case of allergy to antibiotics. In order to institute a cortisone treatment without danger, the corneal sensitivity should first be measured, and aureomycin or terramycin should be administered.

INTRAUTERINE BLOOD TRANSFUSION IN CASES OF RHESUS SENSITIVITY

J. Bennenbroek et al. (Academisch Zienhuis, Leiden, Holland)

Ned. T. Geneesk. 110:1085-1097, (June 11), 1966.

In two successful cases of intrauterine intraperitoneal blood transfusions, both fetuses suffered from severe anemia resulting from Rhesus immunization. After spectrophotometric analysis of amniotic fluid by amniocentesis, intraperitoneal transfusion adequately combated fetal anemia, and was less hazardous than exchange transfusions of the fetus which could have been performed only after the babies were born.

PELVIC FRACTURES: ASSOCIATED INTESTINAL AND MESENTERIC LESIONS

J. R. Moore (Royal Victoria Hosp., Montreal)

Canad. J. Surg. 9:253-261, (July), 1966.

One thousand three hundred and nine pelvic fractures were reviewed to determine the percentage of patients with intra-abdominal injury, to study the effects of non-penetrating trauma, and to delineate associated problems. Intestinal perforation was the most common intra-abdominal visceral lesion. Twenty-five patients had gut perforation, eight had mesenteric lacerations, and one had mesenteric lesions only. In 23 cases, injury was caused by non-penetrating trauma, and in many the perforations involved both the large and the small bowel. Gut injury caused significant hemorrhage in one case. When mesenteric laceration occurred in areas opposing or unrelated to perforation, a high mortality rate resulted. Shock frequently masked symptoms and signs. Retroperitoneal hemorrhage sometimes was indistinguishable clinically from intra-abdominal trauma, and external evidence of injury often was unreliable as an indicator of the presence or site of intra-abdominal damage.

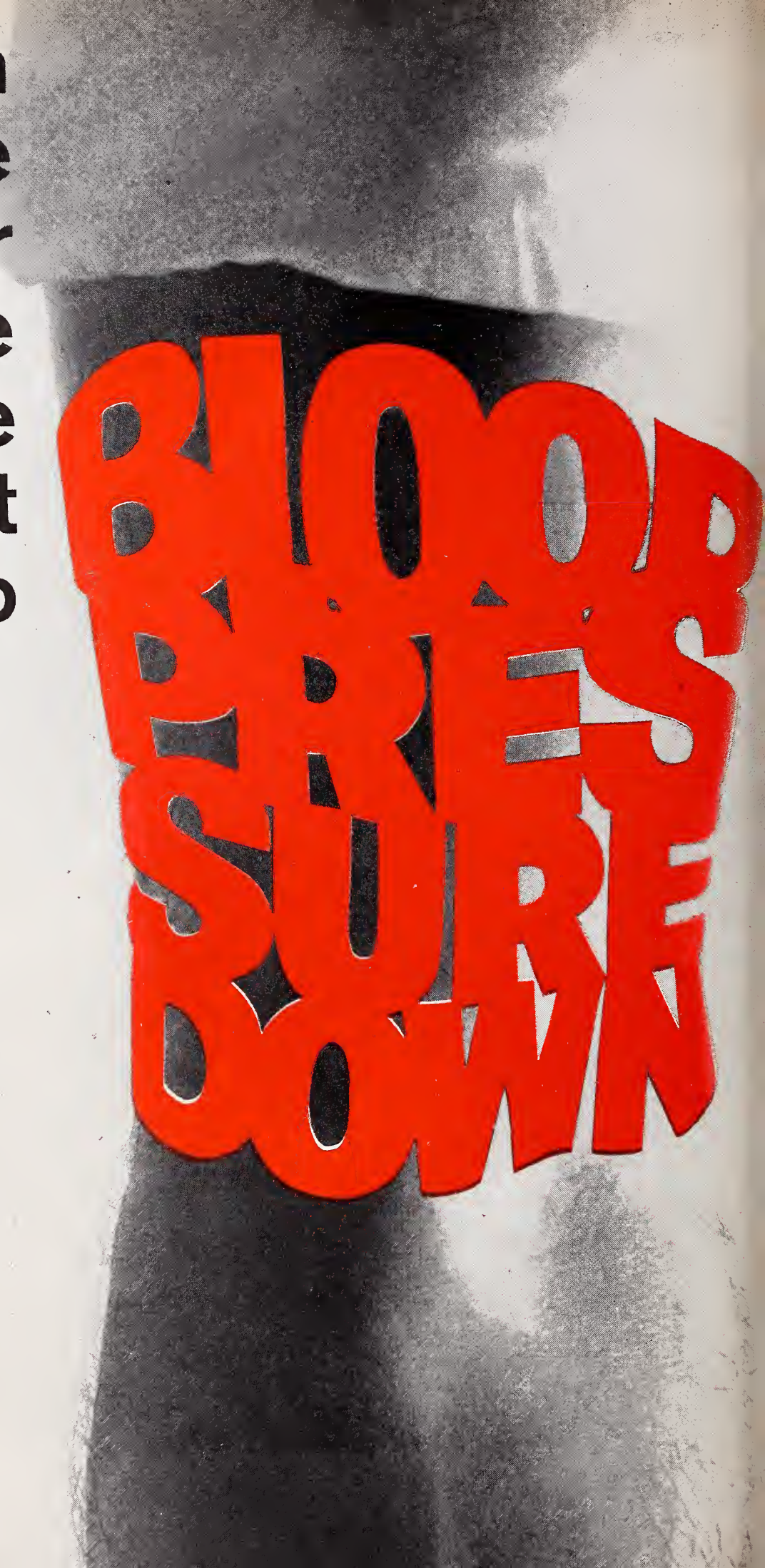
SEVERE WATER AND ELECTROLYTE LOSS DUE TO A VILLOUS ADENOMA OF THE RECTOSIGMOID

G. Kanzler and J. Kort (Klinikum Essen der Universitat Munster, Hufelandstr. 55, Essen, Germany)

Deutsch. Med. Wschr. 91:1365-1369, (Aug. 5), 1966.

As a result of profuse mucous diarrhea from the rectosigmoid, severe water and electrolyte loss occurred in four patients with villous adenoma in this part. In all, the diagnosis was confirmed by rectoscopy and biopsy. Intensive intravenous therapy was followed by successful resection of the villous adenoma, one of which showed malignant degeneration, with complete cure. ◄

When thiazide or reserpine alone won't keep



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Corcoran, A. C.: The choice of drugs in the treatment of hypertension. In: Drugs of Choice 1966-67, W. Modell, Ed., St. Louis, C. V. Mosby Company, 1966, p. 417.

Indications: DIUTENSEN-R may be employed in all grades of essential hypertension. **Dosages:** Usual dose is 1 tablet twice daily, at morning and evening meals. However, adjustment of dosage to suit individual circumstances may be required. Please refer to package insert for full particulars. **Side effects and precautions:** The side effects observed with patients on DIUTENSEN-R have been of a mild and nonlimiting nature. These include occasional urinary frequency, nocturia, nasal congestion, muscle cramps, skin rash, joint pains due to gout symptoms and nausea and dizziness which have been reported for the individual components. Most of these symptoms disappear while the drug is continued at the same or lower dosage level. The concomitant use of digitalis and DIUTENSEN-R may increase the possibility of digitalis-like intoxication. If there is evidence of myocardial irritability (extrasystoles, bigeminy or AV block), dosage of DIUTENSEN-R should be reduced or discontinued. Nocturia in patients with marginal cardiac status and salt and fluid retention can be effectively controlled by limiting the time of administration to early afternoon. DIUTENSEN-R should not be used in patients with a known intolerance to reserpine. Package inserts furnish a complete summary of recommended cautions related to each of the ingredients of DIUTENSEN-R.

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FUTURE MEETINGS, SEMINARS, COURSES

Third Pan American Cancer Cytology Congress Will Meet May 7-11, 1967

The Third Pan American Cancer Cytology Congress will meet at the Waldorf Astoria in New York City, May 7 through 11, 1967.

Clinicians, cytologists, pathologists and research scientists are invited to attend. Full particulars may be obtained from Dr. J. Ernest Ayre, 115 E. 69th St., New York City 10021.

ISMA Members Invited to Sectional Meeting of American College of Surgeons

Members of ISMA are invited to attend a sectional meeting of the American College of Surgeons at the Broadmoor Hotel in Colorado Springs, February 15 to 17, 1967.

Technics of handling problems encountered in day-to-day practice will be discussed. Panel discussions, special reports, "How-I-do-it" clinics and medical films will concern acceptable and new treatment.

There will be a similar sectional meeting in New York City, February 27 to March 2. Inquiries should be addressed to Dr. Woodrow L. Pickhardt, 55 E. Erie St., Chicago 60611.

Socio-Economics of Health Care National Congress January 22-23, 1967

Socio-Economics of Health Care will be discussed at a national congress by the same name to be held in Chicago on January 22 and 23, 1967. The Congress is the first of its kind and will be sponsored by the AMA Council on Medical Service and the AMA Division of Socio-Economic Activities.

Scheduled at the Palmer House, the meeting will bring together authorities from medicine, health care administration, social science, education, community planning and others to discuss organization, delivery and financing of health care services. For information and registration details write the AMA Division of Socio-Economic Activities, 535 N. Dearborn, Chicago 60610.

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Medical Director

J. W. Gibbs, M.D.
Associate
Medical Director

American Academy of Forensic Sciences Annual Meeting in Honolulu

The American Academy of Forensic Sciences will hold its annual meeting in Honolulu at the Princess Kaiulani Hotel from February 20 to 25, 1967.

Write to Dr. Alvin V. Majoska, 1455 S. Beretania St., Honolulu 96814, for details of travel and of sightseeing trips both before and after the convention. The scientific program will be published later and can be obtained by writing Dr. Majoska.

American Cancer Society Will Conduct Annual Scientific Session May 3, 1967

The American Cancer Society will conduct its annual scientific session at the Sheraton-Dallas Hotel in Dallas on May 3, 1967. The theme of the meeting will be "Current Concepts in Etiology and Diagnosis of Cancer."

Members of ISMA are all invited and are urged to attend. There is no registration fee. Copies of the program may be obtained by writing the Society at 219 E. 42nd St., New York City 10017.

40th Annual Spring Congress In Ophthalmology, Otolaryngology

The Gill Memorial Eye, Ear and Throat Hospital of Roanoke, Virginia will conduct its fortieth annual spring congress in ophthalmology and otolaryngology from April 3 through 7, 1967.

A visiting faculty of distinguished specialists will participate. For full particulars write: Superintendent, P. O. Box 1789, Roanoke, Virginia.

First Clinical Meeting Set for Society for Cryo-Ophthalmology

The first annual clinical meeting of the Society for Cryo-Ophthalmology will be held at the Dunes Hotel, Las Vegas, January 8 to 10, 1967.

The clinical aspects of cryo-ophthalmology will be stressed including cataract, glaucoma, retinal detachment and herpetic keratitis. Write Dr. John G. Bellows, 30 N. Michigan Ave., Chicago 60602.

Cleveland Clinic Announces Course in Ophthalmology

The Cleveland Clinic Educational Foundation will present a postgraduate course in ophthalmology December 7 and 8 at Cleveland.

Registration fee is $30.00. Further information on the course may be obtained by writing the Director of Education, Cleveland Clinic Educational Foundation, 2020 E. 93rd St., Cleveland 44106. ◄

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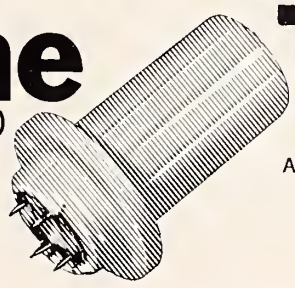

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Indications: Indicated in the therapy of acute severe infections caused by susceptible organisms and primarily by bacteria more sensitive to the combination than to either component alone. In any infection in which the patient can be expected to respond to a single antibiotic, the combination is not recommended. Signemycin should not be used where a bacteriologically more effective or less toxic agent is available. *Triacetyloleandomycin, a constituent of Signemycin, has been associated with deleterious changes in liver function.* See precautions and adverse reactions.

Contraindications: Contraindicated in individuals who have shown hypersensitivity to any of its components. Not recommended for prophylaxis or in the management of infectious processes which may require more than 10 days of continuous therapy. If clinical judgement dictates therapy for longer periods, serial monitoring of liver function is recommended. Not recommended for subjects who have shown abnormal liver function tests, or hepatotoxic reactions to triacetyloleandomycin.

Precautions and Adverse Reactions: Triacetyloleandomycin, administered to adults in daily oral doses of 1.0 gm. for 10 or more days, may produce hepatic dysfunction and jaundice. Adults requiring 3 gm. of Signemycin initially should have liver function followed carefully and the dosage should be reduced as promptly as possible to the usual recommended range of 1.0 to 2.0 gm. per day. Present clinical experience indicates that the observed changes in liver function are reversible after discontinuation of the drug. Use with caution in lower than usual doses in cases with renal impairment to avoid accumulation of tetracycline and possible liver toxicity. If therapy is prolonged under such circumstances, tetracycline serum levels may be advisable. In long term therapy or with intensive treatment or in known or suspected renal dysfunction, periodic laboratory evaluation of the hematopoietic, renal and hepatic systems should be done. Formation of an apparently harmless calcium complex with tetracycline in any bone forming tissue may occur. Use of tetracycline during tooth development (3rd trimester of pregnancy, infancy and early childhood) may cause discoloration of the teeth. Reversible increased intracranial pressure due to an unknown mechanism has been observed occasionally in infants receiving tetracycline. Glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and definite allergic reactions occur rarely. Severe anaphylactoid reactions have been reported as due to triacetyloleandomycin. Photosensitivity and photoallergic reactions (due to the tetracycline) occur rarely. Medication should be discontinued when evidence of significant adverse side effects or reaction is present. Patients should be carefully observed for evidence of overgrowth of nonsusceptible organisms including fungi, which occurs occasionally, and which indicates this drug should be discontinued and appropriate therapy instituted. Steps should be taken to avoid masking syphilis when treating gonorrhea.

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County, District News

Eleventh District

The Eleventh District Medical Society met Sept. 21 in Kokomo, with 67 members present.

James A. Waggener, ISMA executive secretary, Herbert Dixon, physician relations director of Blue Shield, and Dr. E. S. Rifner, president-elect of ISMA, were among the principal speakers. Dr. Joseph Bean, Logansport was elected president; Dr. Fred Poehler, LaFountain, secretary-treasurer; Dr. Lowell J. Hillis, councilor: Dr. James A. Harshman, Kokomo, alternate councilor and Dr. Christos Gatzimos, Logansport, necrologist. The 1967 meeting will be Sept. 13 at Logansport.

Allen

The Allen County Medical Society met Sept. 6 to hear Dr. E. Stanley Crawford of Baylor University speak on "The Surgical Treatment of Occlusive Vascular Disease."

Cass

The Cass County Medical Society met October 3 and passed two additional resolutions to be presented at the ISMA convention.

Elkhart

Dr. Mark Dyken, professor of neurosurgery at the I. U. Medical Center, spoke on "Strokes — Diagnosis and Management" at the October 6 meeting of the Elkhart County Medical Society.

Marion

Dr. William Lybrook is the new president of the Marion County Medical Society. Dr. Charles Cure was re-elected secretary-treasurer.

Parke-Vermillion

The Parke-Vermillion County Medical Society met Sept. 21 to hear Dr. H. J. Walden of Terre Haute speak on the topic of "Drug Addiction."

Tippecanoe

Dr. Fran McAree, Indianapolis, spoke at the Sept. 13 meeting of the Tippecanoe County Medical Society on the "Planned Parenthood Association." There were 65 members and guests present.

Vanderburgh

Mr. Donald R. Balser of Old National Bank discussed "Estate Planning" at the Sept. 13 meeting of the Vanderburgh County Medical Society.

Wayne-Union

The Wayne-Union County Medical Society met Sept. 13 at Reid Memorial Hospital. Speaker was Mrs. Elizabeth Clighorn. Her topic was "RICOE and Rehabilitation." New members accepted into the society were Drs. John Dehner, John Short, John Clouse and John Wambo. ◄

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Deaths

Oren L. Kirklin, M.D.

Dr. Oren L. Kirklin, Indianapolis physician for many years, died Sept. 16 in St. Vincent's Hospital. He was 63.

Graduated from the Indiana University School of Medicine in 1928, Dr. Kirklin began his practice in Indianapolis in 1947 after a number of years at the Mayo Clinic. He was a member of the Marion County Medical Society and specialized in internal medicine.

Jacob Paskind, M.D.

Dr. Jacob Paskind, 73, chief psychiatrist at General Hospital, died Aug. 14 at Methodist Hospital.

A psychiatrist in Chicago for many years, Dr. Paskind came to Indianapolis 10 years ago. He was on the staff at the I. U. Medical Center as well as serving at the hospital when he died. Graduated from the University of Illinois in 1916, Dr. Paskind was Professor Emeritus of that university. He also was a retired colonel in the U. S. Army and served in World War I and II. Dr. Paskind was a member of the Marion County Medical Society and the ISMA 50-Year Club.

Franklin G. Rudolph, M.D.

Dr. Franklin G. Rudolph, 51, Hammond physician since 1940, died Sept. 10 in his home.

Graduated from the Indiana University School of Medicine in 1939, Dr. Rudolph was a general practitioner and member of the Lake County Medical Society. He was also a member of the medical staff of St. Margaret Hospital.

Jack J. Turner, M.D.

Dr. Jack J. Turner, 45-year-old Bloomfield physician, died Oct. 4 in his home.

Dr. Turner was graduated from the University of Louisville School of Medicine in 1946 and had shared an office with his father, Dr. H. B. Turner, since them. He was on the staff of the Freeman Greene County Hospital and a member of the Greene County Medical Society. ◄

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Association News

EXECUTIVE COMMITTEE

September 18, 1966

Present: Ralph V. Everly, M.D., chairman; G. O. Larson, M.D.; Kenneth O. Neumann, M.D.; Eugene S. Rifner, M.D.; E. T. Edwards, M.D.; Ottis N. Olvey, M.D.

Robert Hollowell, attorney, and James A. Waggener, executive secretary.

Membership Report

Number of members as of December 31, 1965	4,394
1966 members as of August 31, 1966:	
Full dues paying	3,857
Residents and interns	116
Council remitted	51
Senior	310
Honorary	3
Military	37
Total 1966 members as of August 31, 1966	4,374
Number of members as of August 31, 1965	4,370
Gain over last year	4
Number of AMA members as of August 31, 1966	4,259
Total 1965 AMA members as of August 31, 1965	4,267
Loss over last year	8

1966 AMA members:	
Dues paying	3,744
Exempt, but active	515
	4,259
Number who have paid state dues but not AMA dues as of August 31, 1966	115

Headquarters Office

The secretary reported that following instructions of the Executive Committee he had written Blue Cross-Blue Shield for a report on the ISMA group contract and as yet no reply had been received.

The secretary reported that he had received permission from the Federal Government to purchase another cabinet for filing patient record cards, the cost of the cabinet to be amortized to the government. On motion of Drs. Rifner and Neumann, the secretary was authorized to purchase this cabinet.

Treasurer's Office

The treasurer's report was accepted by consent.

Annual Convention, French Lick, Oct. 10, 11, 12 and 13, 1966

Public relations awards. The secretary reported that the Commission on Public Information had sent the material on the public relations awards to the respective county societies but as yet no reply had been received. It was suggested that a follow-up letter be sent to these societies.

Request of the Woman's Auxiliary for money to purchase golf prizes for the women's golf tournament at French Lick was discussed and on motion of Drs. Neumann and Edwards, the auxiliary is to be allowed $50.00 for this purpose.

Legislation

Local: The proposed legislation to implement Title XIX was discussed as well as the memorandum on this bill prepared by Dr. Schuster, chairman of the Commission on Legislation. A discussion was held concerning inclusion in the bill of provisions for a Medical Society Advisory Committee. It was the consensus that the advisory committee should be implemented at the county level. Mr. Hollowell is to draft a proposed amendment for submission to Dr. Kirtley, chairman of the legislative committee preparing this bill.

Organization Matters

A request for financial assistance from the National Conference of State Legislative Leaders was turned down on motion of Drs. Neumann and Edwards.

A report of the actions of the AMA Board of Trustees at their meetings in May, June and July was reviewed for the information of the committee.

A letter from the LaPorte County Medical Society concerning the establishment of a medical school in northern Indiana was reviewed for the information of the committee.

By consent a letter from National Services, Inc., concerning an insurance program for the members of the Indiana State Medical Association was referred to the Commission on Medical Economics and Insurance.

A letter from Dr. A. G. Blazey, addressed to the editor of *The Indianapolis Star*, was read for the information of the committee.

A letter from the American Medical Association under date of August 5 concerning the action of the board of trustees with respect to Resolution 104 was read for the information of the committee.

Resolutions adopted by the American Association of Medical Assistants were reviewed for the information of the committee.

A bulletin from the College of American Pathologists was reviewed for the information of the committee.

A letter from the American Medical Association concerning the Internal Revenue Service ruling on immunization clinics was read for the information of the committee.

A letter from J. Russell Townsend proffering a new contract on the present disability program of the association to increase the coverage of those currently enrolled to have sickness disability to age 65 rather than the five-year limitation as currently provided was approved and the president was instructed to sign the agreement, on motion of Drs. Edwards and Rifner.

Copies of a letter from Dr. Jack D. Furr were distributed to members of the committee for their review.

Medicare

Correspondence between the headquarters office and the Blue Cross and Baltimore regarding certification and assignments was reviewed and the secretary was instructed to continue to press for reply to these letters.

The attorney reviewed the rewrite of the contract between Blue Shield and the State Department of Public Welfare. A report of this had been submitted to the Attorney General for review and if the Attorney General concurred, it is to be presented to the Board of Blue Shield and the Indiana State Medical Association for concurrence before signing.

A lengthy discussion was held concerning complaints by physicians on various aspects of the operation of the new Medicare program.

A letter addressed to Dr. Neumann from Dr. J. P. Donnelly was reviewed by the president for the information of the committee.

The publication, *The Blue Shield*, the bulletin of the American College of Radiology, *The AMA News*, and the *Medicare Newsletter* were reviewed for the information of the committee.

Discussion was held concerning the definition of "usual" and "customary."

New Business

A request for building funds from the Zion Broadway Baptist Missionary Church was turned down by consent.

A request for funds from the Robert Griffin for Senate Committee was turned down by consent.

Correspondence from Smith, Dingwall Associates, Inc., New York, concerning openings for four physicians was reviewed and no one had any suggestions as to who might be interested.

Letter announcing the fact that the LaPorte County Medical Society is placing the name of G. O. Larson, M.D., in nomination for president-elect at the French Lick meeting was read for the information of the committee.

Correspondence between the association and the Madison State Hospital was reviewed for the information of the committee and the secretary was instructed to discuss this with Dr. McAtee.

Future Meetings

The invitation to the association to send a representative to the Governor's Conference on the Handicapped, in Indianapolis, September 28 and 29, 1966, was read. Upon motion of Dr. Neumann, taken by consent, the appropriate commission is to be allowed to name a representative to attend this meeting.

The secretary reported on his efforts to procure mass transportation of the Indiana delegation to the AMA Clinical Meeting in Las Vegas and he is to advise the delegates and committee members when something definite is worked out.

National Congress on Socio-Economics of Health Care, January 22-23, 1967. The secretary is to advise the members of the Commission on Medical Economics and Insurance of this meeting, in case any of the commission members desire to attend at their own expense.

National Medicolegal Symposium, Miami, March 9-11, 1967. By consent Mr. Hollowell was authorized to attend this meeting if time permits.

There being no further business the committee adjourned, to meet again at 7:00 p.m., Sunday, October 9, 1966, at French Lick, Indiana. ◄

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Your Indiana State Medical Association Income Replacement Program has been improved and expanded to make even greater benefits available to association members.

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OPHTHALMOLOGIST: Vigo County, Terre Haute. Population 72,000. Opening at A.P. and S. Clinic. Three colleges, two accredited hospitals. Contact Robert R. Brown, M.D., 221 S. Sixth St., Terre Haute, Ind., or phone collect Lincoln 8071.

SURGEON: Associate needed in proctology, board certified or eligible, American Board of Surgery, who will limit his field to colo-rectal surgery; or American Board of Colon and Rectal Surgery. Write Box 327, The Journal, ISMA, 3935 N. Meridian St., Indianapolis, Ind.

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November 1966 Volume 59 No. 11

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It works.

SUMMARY:

TREST® (METHIXENE HYDROCHLORIDE)

relieves G.I. spasm, hyperactivity and associated pain by directly antagonizing the parasympathetic nervous system.

Each tablet contains methixene hydrochloride, 1 mg.

INDICATIONS: Gastrointestinal Spasm and Hypermotility.

CONTRAINDICATIONS: Pylaric abstruction, gastric retentian, abstructive arganic disease af the gastraintestinal tract, arganic cardiaspasm, duadenal stenosis, stenasing peptic ulcer, and urinary bladder neck obstructian ar prostatic hypertrophy are contraindicatians ta the use af this drug.

WARNING: Overdasage praduces antichalinergic side effects. Althaugh the animal reprauction studies are negative, until there is clinical canfirmatian af safety in pregnancy, this praduct shauld nat be used in women wha may became pregnant unless in the apinian af the physicion the benefits outweigh the risks.

PRECAUTIONS: Use only with caution in patients with certain types of cardiavascular disease, since antichalinergic drugs may cause arrhythmias. Extensive clinical studies of TREST have shawn no evidence af glaucama. However, the possibility exists that it con accur since it has been reparted as a characteristic side effect af antichalinergic drugs. This product daes not replace definitive treatment in arganic gastraintestinol disease.

SIDE EFFECTS: Side effects are generally absent when TREST is used in the recammended dosage of 1 ta 2 mg. three times daily. Uncammonly, allergy ar sensitivity to the drug may be manifested by generalized rash ar widespread desquamatian. In case af pralanged or massive averdosage, dry mauth, blurred vision, and urinary retentian, typical side effects comman ta antichalinergic drugs, may accur. Occasionally, sensitive patients may notice mild dryness af mouth or slight blurring af visian fram dases af 2 mg. ar mare. Most patients talerate single dases of 5 mg. withaut such side effects.

DOSAGE: The usual adult dosage is 1 mg. by mouth three times daily. If necessary, the dase may be increased to 2 mg. three times daily. Pediatric dasage has nat been determined.

CAUTION: Federal law prohibits dispensing withaut prescriptian.

Puts the G.I. tract to rest

DORSEY LABORATORIES • *a division of The Wander Campany* • **Lincoln, Nebraska**

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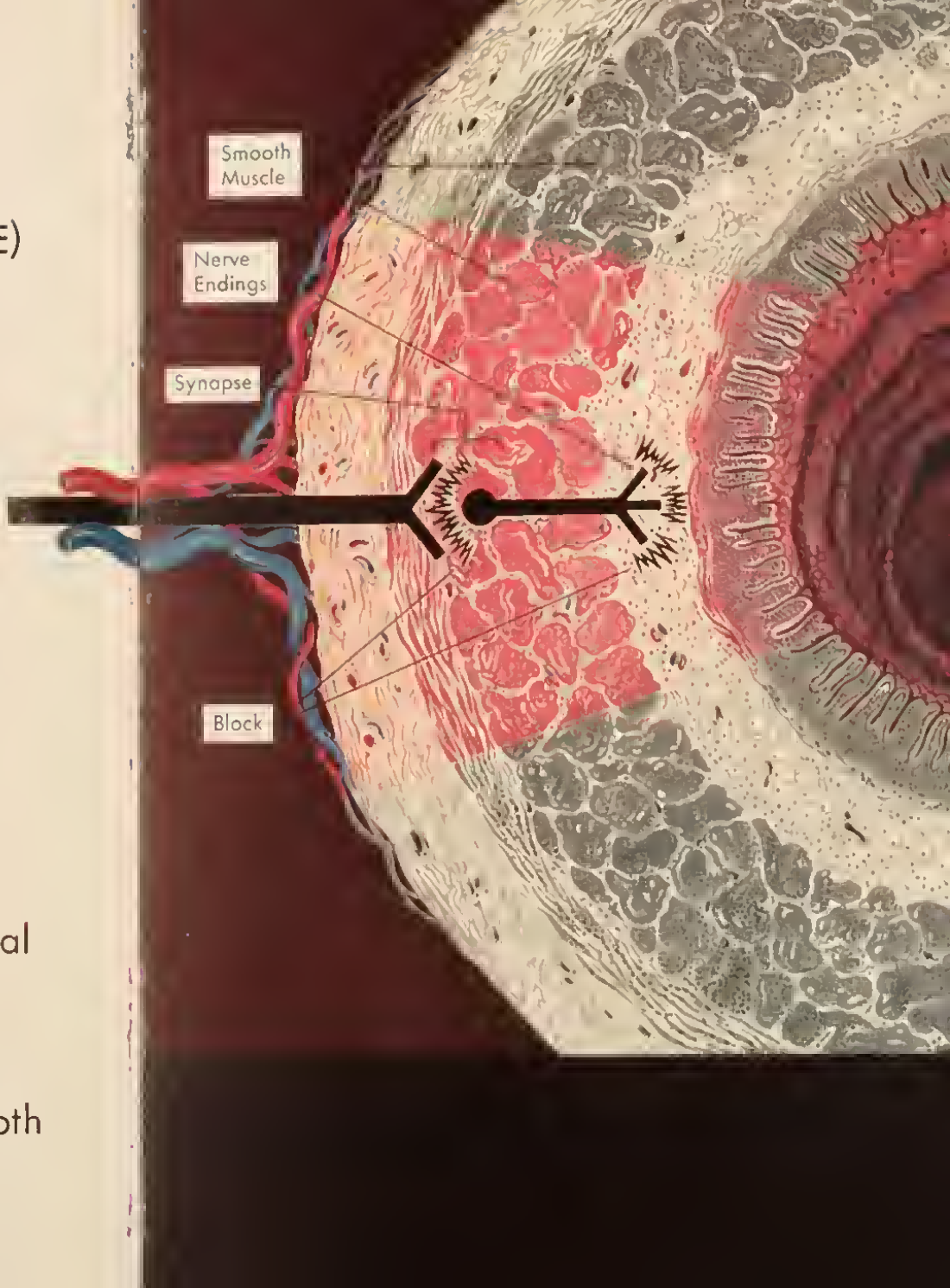
An antispasmodic that antagonizes.

How TREST®
(METHIXENE HYDROCHLORIDE)
works.

parasympathetic nerve

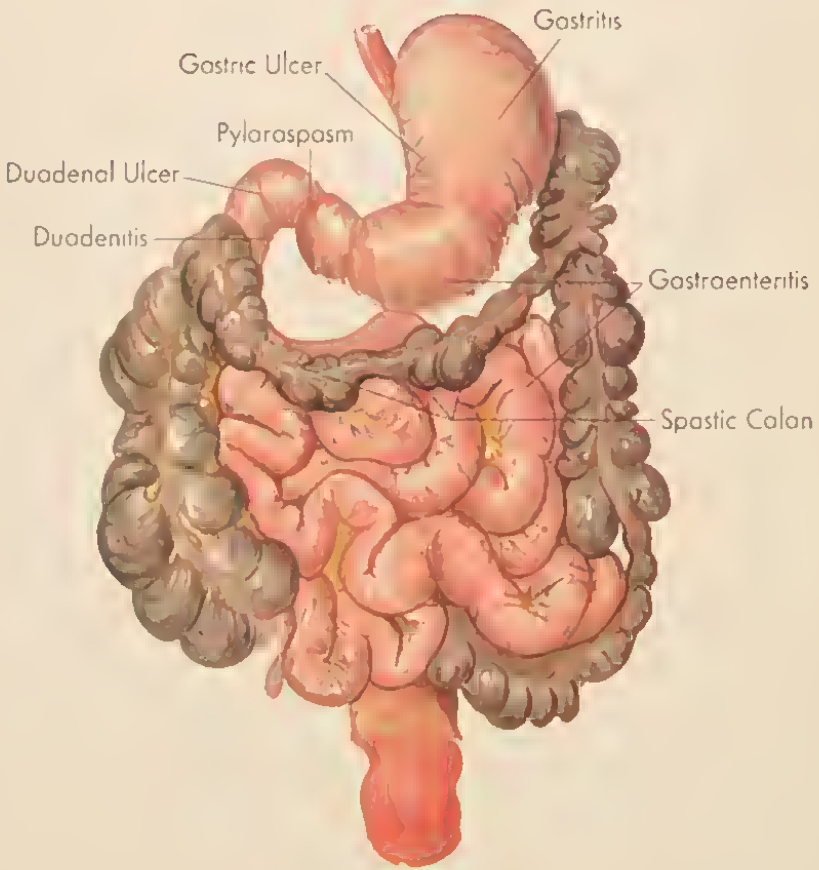


TREST (methixene hydrochloride) directly antagonizes the parasympathetic nervous system.

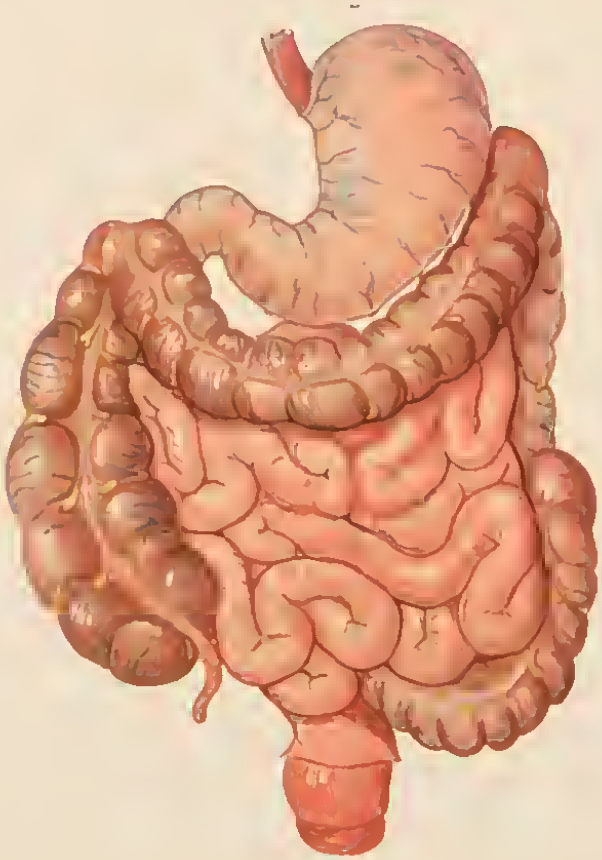
TREST (methixene hydrochloride) blocks the action of acetylcholine formed at the synapses and visceral parasympathetic nerve endings.

Therefore, nerve impulses are prevented from reaching the smooth muscle layer.

TREST® (METHIXENE HYDROCHLORIDE)
relieves gastrointestinal spasm, hyperactivity and associated pain in:



Put the gut to rest
with your prescription for
TREST®
(METHIXENE HYDROCHLORIDE)



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(METHIXENE HYDROCHLORIDE) works.

EFFECTIVENESS AND SAFETY

t.i.d. dosage in milligrams

1 mg. symptomatic relief

2 mg. upper recommended clinical dose/greater pharmacologic activity and symptomatic relief/side effects uncommon

10 mg.

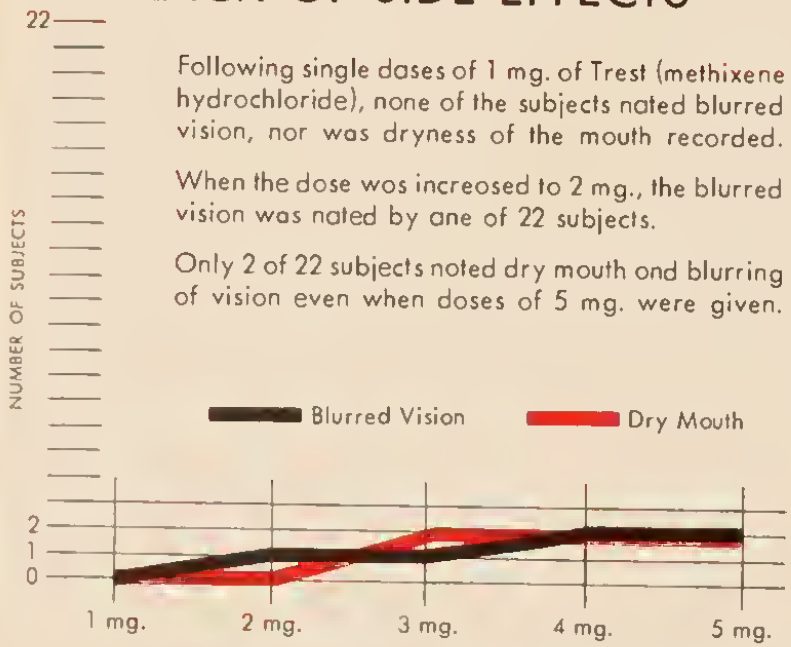
Studies with 372 subjects revealed no adverse effect upon vital organs when dosage was increased 10 times the normally effective dose of 1 mg. t.i.d. for periods up to 2½ years of continued administration.

LACK OF SIDE EFFECTS

Following single doses of 1 mg. of Trest (methixene hydrochloride), none of the subjects noted blurred vision, nor was dryness of the mouth recorded.

When the dose was increased to 2 mg., the blurred vision was noted by one of 22 subjects.

Only 2 of 22 subjects noted dry mouth and blurring of vision even when doses of 5 mg. were given.



Conclusion: Typical atropine-like side effects are not expected when Trest is used 1 mg. t.i.d. These effects are uncommon when the dosage is increased to 2 mg. t.i.d.

"A highly satisfactory symptomatic response was obtained in 20 of the 23 patients who took 1 mg. of methixene hydrochloride (Trest) by mouth three times daily. No side effects occurred at this dosage during administration of the medication itself.

"Methixene hydrochloride (Trest) provides highly gratifying symptomatic relief in a variety of conditions associated with gastrointestinal motility without producing the usual atropine-like side effects and without requiring concurrent barbiturate sedation."

—Martins, J. K.: Clin. Med. 72:1313-1316 (Aug.) 1965.

". . . in a series of 47 patients suffering from various types of functional bowel distress. The superiority of this drug (Trest) in dosage of 1.0 mg. three times daily by mouth over the placebo is statistically significant. At that dosage level, side effects were not observed."

—Hufford, A. R.: Clin. Med. 72:1151-1155 (July) 1965.

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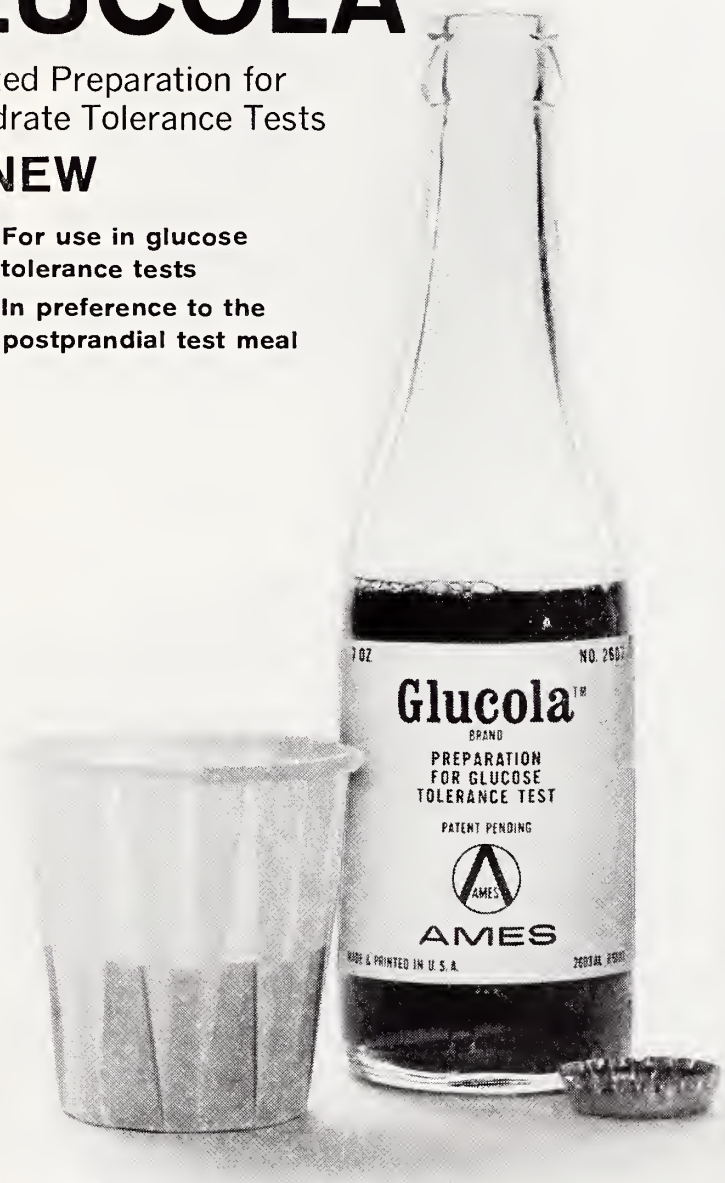

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Warn against hazardous occupations requiring complete mental alertness. Use caution in administering to addiction-prone patients or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of child-bearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In elderly and debilitated and in children over five, limit dosage to smallest effective amount, increasing gradually as needed and tolerated. In general, concomitant use with other psychotropics is not recommended. Paradoxical reactions have been reported in psychiatric patients and hyperactive aggressive children. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically. Observe usual precautions in presence of impaired renal or hepatic function, impending depression and suicidal tendencies.

Adverse reactions: Drowsiness, ataxia and confusion may occur, especially in elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. Syncope occurs rarely. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis, jaundice and hepatic dysfunction) may develop occasionally, making periodic blood counts and liver-function tests advisable during protracted therapy. Individual maintenance dosages should be determined.

Dosage: *Oral*—Adults: Mild to moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d.

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2 (*And this taxing was first made when Cyrenius was governor of Syria.)
3 And all went to be taxed, every one into his own city.
4 And Joseph also went up from Galilee, out of the city of Nazareth, into Judea, unto *the city of David, which is called Bethlehem, (because he was of the house and lineage of David,)
5 To be taxed with Mary *his espoused wife, being great with child.
6 And so it was, that while they were there, the days were accomplished that she should be delivered.
7 And *she brought forth her first-born son, and wrapped him in swaddling-clothes, and laid him in a manger; because there was no room for them in the inn.
8 And there were in the same country shepherds abiding in the field, keeping ‖ watch over their flock by night.
9 And lo, the angel of the Lord came upon them, and the glory of the Lord shone round about them; *and they were sore afraid.
10 And the angel said unto them, Fear not: for behold, I bring you good tidings of great joy, *which shall be to all people.
11 *For unto you is born this day, in the city of David, *a Saviour, *which is Christ the Lord.
12 And this *shall be* a sign unto you; Ye shall find the babe wrapped in swaddling-clothes, lying in a manger.
13 *And suddenly there was with the angel a multitude of the heavenly host praising God, and saying,
14 *Glory to God in the highest, and on earth *peace, *good will toward men.
15 And it came to pass, as the angels were gone away from them into heaven, † the shepherds said one to another, Let us now go even unto Bethlehem, and see this thing which is come to pass, which the Lord hath made known unto us.
16 And they came with haste, and found Mary and Joseph, and the babe lying in a manger.
17 And when they had seen *it*, they made known abroad the saying which was told them concerning this child.
18 And all they that heard *it*, wondered at those things which were told them by the shepherds.
19 *But Mary kept all these things, and pondered *them* in her heart.
20 And the shepherds returned, glorifying and praising God for all the things that they had heard and seen, as it was told unto them.
21 *And when eight days were accomplished for the circumcising of the child, his name was called JESUS, which was so named of the angel before he was conceived in the womb.
22 And when the days of her purification according to the law of Moses were accomplished, they brought him to Jerusalem, to present him to the Lord;

Before the Account called Anno Domini the Fifth Year

a Acts 5.37
b 1 Sam.16. 1, 4. John 7. 42.
c Matt.1.16 ch. 1. 27.
d Matt. 1. 18. ch. 1. 27.
e Matt. 1. 25.
‖ Or, *the night-watches.*
f ch. 1. 12.
g Gen.12.3. Matt.28.19. Mark 1. 15. ver. 31, 32. ch. 24. 47. Col. 1. 23.
h Isa. 9. 6.
i Matt. 1.21
k Matt. 1. 16.& 16. 16. ch. 1. 43. Acts 2. 36. & 10. 36. Phil. 2. 11.
l Gen. 28. 12.& 32.1,2. Ps. 103. 20, 21. & 148. 2. Dan. 7. 10. Heb. 1. 14. Rev. 5. 11.
m ch.19.38. Eph. 1. 6. & 3. 10, 21. Rev. 5. 13.
n Isa. 57. 19. ch. 1. 79. Rom. 5. 1. Eph. 2. 17. Col. 1. 20.
o John 3.16 Eph. 2. 4, 7. 2 Thess. 2. 16. 1 John 4. 9, 10.
† Or. *the men the shepherds.*
p Gen. 37. 11. ch. 1. 66. ver. 51.

Before the Account called Anno Domini the Fourth Year.

q Ps. 69. 48. Heb. 11. 8.
r Matt. 4.1.
a Gen. 48. 30. Phil. 1. 23.
b Isa.52.10. ch. 3. 6.
c Isa. 9. 2. & 42. 6. & 49. 6. & 60. 1, 2, 3. Matt. 4. 16. Acts 13. 47. & 26. 23.
d Isa. 8.14. Hos. 14. 9. Matt. 21. 44. Rom. 9. 32, 33. 1 Cor. 1. 23, 24. 2 Cor. 2. 16. 1 Pet. 2. 7, 8.
e Acts 28. 22.
f Ps. 42.10. John 19. 25.
g Acts 26.7. 1 Tim. 5. 5.
h Mark 15. 43. ver. 25. ch. 24. 21.
‖ Or, *Israel.*
i ver. 52. ch. 1. 80.
k Ex. 23.15, 17.& 34. 23. Deut. 16. 1, 16.
A. D. 8.

23 (As it is written in the law of the Lord, Every male that openeth the matrix shall be called holy to the Lord;)
24 And to offer a sacrifice according to that which is spoken in the law of the Lord, A pair of turtledoves, or two young pigeons.
25 And behold, there was a man in Jerusalem, whose name was Simeon; and the same man was just and devout, waiting for the consolation of Israel: and the Holy Ghost was upon him.
26 And it was revealed unto him by the Holy Ghost, that he should not see death, before he had seen the Lord's Christ.
27 And he came *by the Spirit into the temple: and when the parents brought in the child Jesus, to do for him after the custom of the law,
28 Then took he him up in his arms, and blessed God, and said,
29 Lord, *now lettest thou thy servant depart in peace, according to thy word:
30 For mine eyes *have seen thy salvation,
31 Which thou hast prepared before the face of all people;
32 *A light to lighten the Gentiles, and the glory of thy people Israel.
33 And Joseph and his mother marvelled at those things which were spoken of him.
34 And Simeon blessed them, and spake unto his mother, Behold, this *child* is set for the fall and rising again of many in Israel; and for a sign which shall be spoken against;
35 (Yea, *a sword shall pierce through thine own soul also;) that the thoughts of many hearts may be revealed.
36 And there was one Anna, a prophetess, the daughter of Phanuel, of the tribe of Aser: she was of a great age, and had lived with an husband seven years from her virginity;
37 And she *was* a widow of about fourscore and four years, which departed not from the temple, but served *God* with fastings and prayers night and day.
38 And she coming in that instant gave thanks likewise unto the Lord, and spake of him to all them that *looked for redemption in Israel.
39 And when they had performed all things according to the law of the Lord, they returned into Galilee, to their own city Nazareth.
40 *And the child grew, and waxed strong in spirit, filled with wisdom: and the grace of God was upon him.
41 Now his parents went to Jerusalem every year at the feast of the passover.
42 And when he was twelve years old, they went up to Jerusalem after the custom of the feast.
43 And when they had fulfilled the days, as they returned, the child Jesus tarried behind in Jerusalem; and Joseph and his mother knew not of it.
44 But they, supposing him to have been in the company, went a day's journey; and they sought him among their kinsfolk and acquaintance.

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whatever their color, shape, or size...

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for control of allergic symptoms

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Entered as second class matter January 25, 1933, at the Postoffice at Indianapolis, Indiana. Copyright, 1966 by the Indiana State Medical Association. Published monthly at 3935 N. Meridian, Indianapolis 46208.

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10—Lawell H. Steen, Whiting (Chairman)	Oct. 1968
11—Lawell Hillis, Laganspart	Oct. 1969
12—Miltan F. Papp, Fart Wayne	Oct. 1967
13—Otis R. Bawen, Bremen	Oct. 1968

ALTERNATE COUNCILORS

District	Term Expires
1—Gilbert M. Wilhelmus, Evansville	1967
2—	
3—Elmer L. Wallace, New Albany	1968
4—Jack E. Shields, Brawnstawn	1967
5—A. W. Cavins, Terre Haute	1967
6—Frank Green, Rushville	1969
7—Jahn O. Butler, Indianapalis	1969
8—Paul Sparks, Winchester	1967
9—Clarence G. Kern, Lebanan	Fall, 1968
10—Herman Wing, Gary	1969
11—James A. Harshman, Kakama	1969
12—William Clark, Fort Wayne	Spring, 1968
13—George B. Gattman, Elkhart	1967

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Vice-chairman—Danald M. Schlegel, Indianapalis
Secretary—Henry Larzelere, Marian

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Vice-chairman—Lauis Sandack, South Bend
Secretary—Rabert L. Rudesill, Indianapalis

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Vice-chairman—M. Richard Harding, Indianapalis
Secretary—Gearge A. Clark, Indianapalis

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Vice-chairman—William M. Matthews, Indianapalis
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Vice-chairman—Jay S. Reese, Martinsville
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Vice-chairman—Rabert M. Reid, Calumbus
Secretary—Tam W. Wachob, Jr., Kokamo

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Secretary—Henry G. Nester, Indianapalis

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Terms expire December 31, 1966:

Delegates	Alternates
Harald C. Ochsner, Indianapolis	James H. Gasman, Indianapalis
E. S. Janes, Hammand	Rabert M. Brawn, Marian
Frank H. Green, Rushville	Kenneth O. Neumann, Lafayette

Terms expire December 31, 1967:

Delegates	Alternates
Guy A. Owsley, Hartfard City	Maurice E. Glack, Fart Wayne
Jack E. Shields, Brawnstown	Dwight W. Schuster, Indianapalis

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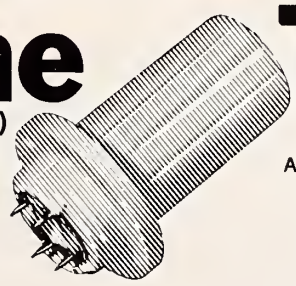

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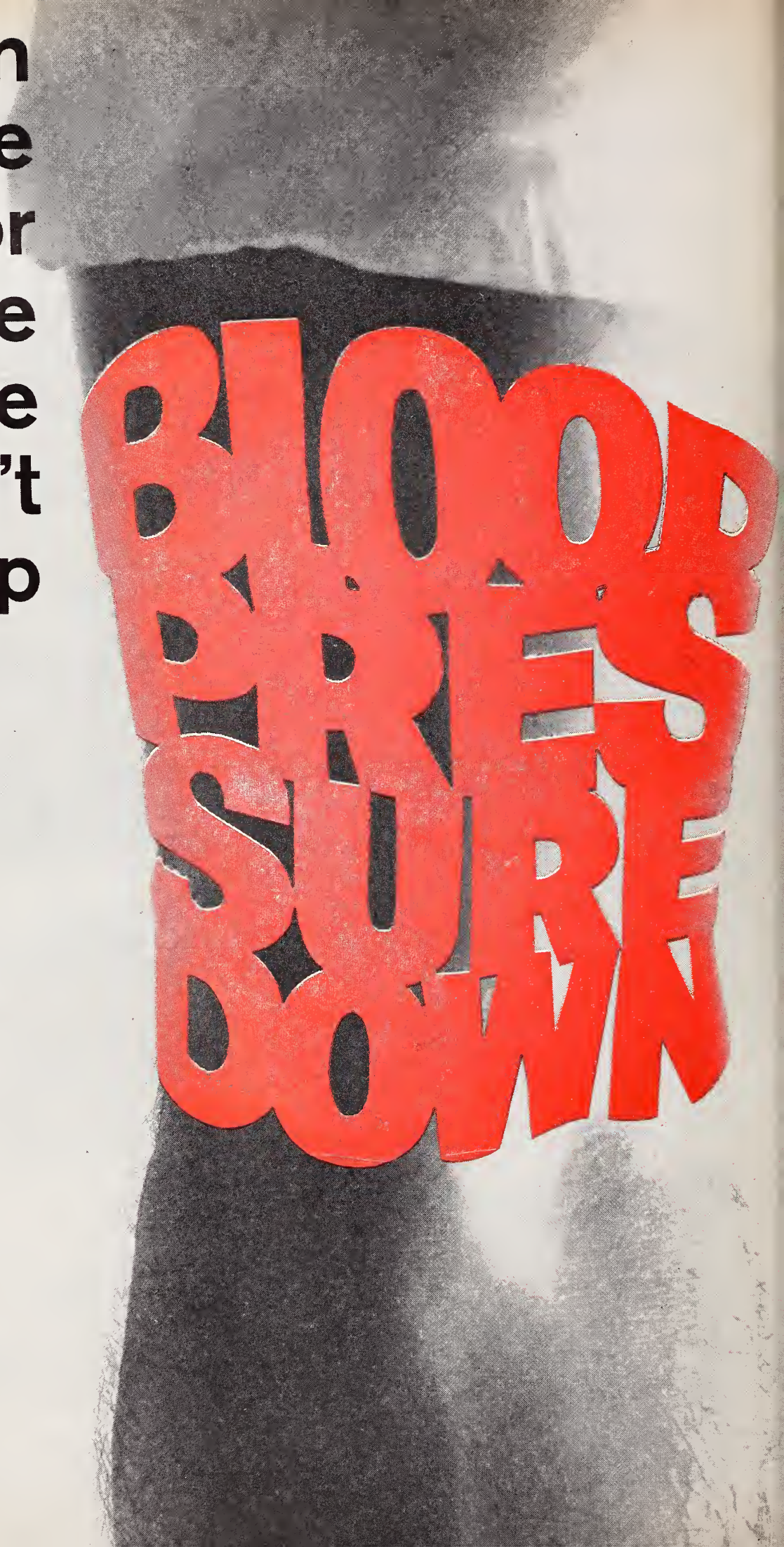

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Cryptenamine 1.0 mg.* Methyclothiazide 2.5 mg. Reserpine 0.1 mg.

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The cryptenamine in DIUTENSEN-R helps improve normal vasodilating reflexes while the thiazide and reserpine components maintain vasorelaxant, sedative, and saluretic benefits. Cryptenamine lowers pressoreceptor reflex thresholds (which may be abnormally high in hypertension)—"resets" pressoreceptors to function at more nearly normotensive levels.

Early, more decisive control with DIUTENSEN-R helps secure continuing benefits—may reduce or even obviate the need for poorly tolerated drugs later in therapy.

"...quite apart from the problem of vascular damage, there arises a possibility of virtual 'cure' or remission of hypertension when treatment is early, i.e., before too many other secondary pressor systems have entered into the disequilibrium of pressor control, and when it is adequately suppressive."

Corcoran, A. C.: The choice of drugs in the treatment of hypertension. In: Drugs of Choice 1966-67, W. Modell, Ed., St. Louis, C. V. Mosby Company, 1966, p. 417.

Indications: DIUTENSEN-R may be employed in all grades of essential hypertension. **Dosages:** Usual dose is 1 tablet twice daily, at morning and evening meals. However, adjustment of dosage to suit individual circumstances may be required. Please refer to package insert for full particulars. **Side effects and precautions:** The side effects observed with patients on DIUTENSEN-R have been of a mild and nonlimiting nature. These include occasional urinary frequency, nocturia, nasal congestion, muscle cramps, skin rash, joint pains due to gout symptoms and nausea and dizziness which have been reported for the individual components. Most of these symptoms disappear while the drug is continued at the same or lower dosage level. The concomitant use of digitalis and DIUTENSEN-R may increase the possibility of digitalis-like intoxication. If there is evidence of myocardial irritability (extrasystoles, bigeminy or AV block), dosage of DIUTENSEN-R should be reduced or discontinued. Nocturia in patients with marginal cardiac status and salt and fluid retention can be effectively controlled by limiting the time of administration to early afternoon. DIUTENSEN-R should not be used in patients with a known intolerance to reserpine. Package inserts furnish a complete summary of recommended cautions related to each of the ingredients of DIUTENSEN-R.

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2.	C. Philip Fox, Washington	J. S. Brown, Carlisle	
3.	Daniel H. Cannon, New Albany	Elmer L. Wallace, New Albany	May 17, 1967
4.	Harold W. Richmond, Columbus	David L. Adler, Columbus	Columbus, 1967
5.	John Ellett, Jr., Cootesville	Richard Veach, Boinbridge	Greencastle, May 17, 1967
6.	J. J. Farrell, Jr., Greenfield	Stephen D. Smith, Knightstown	
7.	Jay Reese, Martinsville	James H. Gosman, Indianapolis	
8.	Donald E. Spahr, Portland	Joseph F. Vormohr, Portland	Portland, June 7, 1967
9.	Harry T. Stout, Fronkfort	Earl K. Williams, Frankfort	May 18, 1967
10.	Leslie Bombor, Munster	Louis Kudele, Whiting	
11.	Joseph Bean, Logansport	Fred Poehler, LaFountoin	Logansport, Sept. 13, 1967
12.	Warren L. Niccum, Columbia City	Kenneth F. Isenogle, Fort Wayne	Fort Wayne, May 17, 1967
13.	James W. Hurley, Elkhart	Cecil R. Burket, Bremen	

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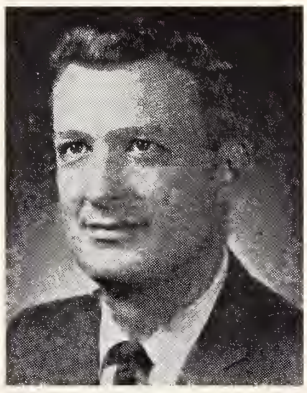
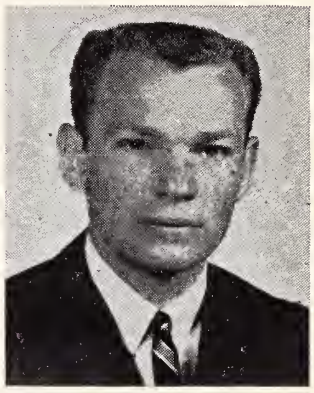


Jerry Johnson
Elkhart, Indiana
264-0362



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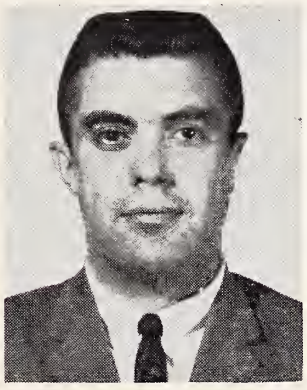

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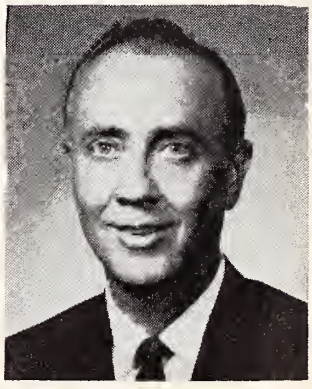

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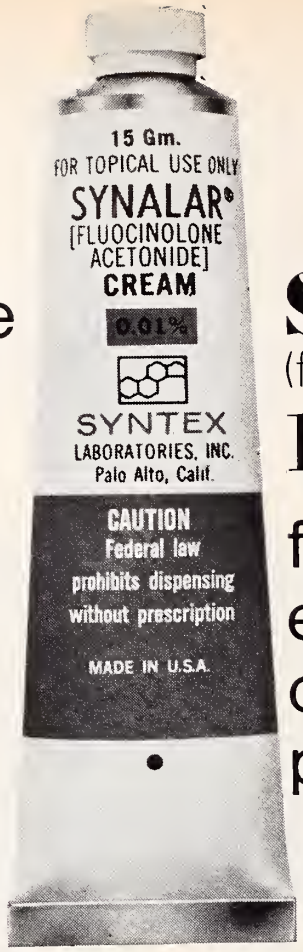

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Contraindications: Tuberculous, fungal, and most viral lesions of the skin (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of its components. **Precautions:** 1. *General*—Synalar Cream 0.01% is virtually nonsensitizing and nonirritating. Where severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. 2. *Occlusive dressing method*—With occlusion of extensive areas, systemic absorption of the corticosteroid may occur, and suitable precautions should be taken. Occasional patients may show contact sensitivity to a particular dressing material or adhesive. Miliaria, folliculitis, or pyodermas have been seen infrequently with the use of this technique. The development of infection requires appropriate antibacterial therapy and discontinuation of the occlusive dressing method. Local atrophy and striae have been reported with protracted occlusive dressing therapy. While lesion relapses can be expected to occur in many psoriatic patients, remissions may persist for several weeks to several months in favorable cases. The patient whose psoriasis is in an active stage, with recent appearance of new lesions, may not be a good candidate and may show early relapse. Some plastic films may be flammable, and due care should be exercised in their use. Similarly, caution should be employed when such films are used on or left near children to avoid the possibility of accidental suffocation. **Side Effects:** Side effects are not ordinarily encountered with topically applied corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. **References:** 1. Cahn, M. M., and Levy, E. J.: J New Drugs 1:262 (Nov.-Dec.) 1961. 2. Meenan, F. O.: J Irish Med Ass 52:75 (Mar.) 1963. 3. Robinson, H. M., Jr., Raskin, J., and Dunseath, W. J. R.: Southern Med J 56:797 (Jul.) 1963.

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for multiple contraceptive action that has produced a record of unexcelled effectiveness

inhibition of ovulation by means of 2 time-proved hormonal agents

production of a cervical mucus hostile to sperm motility and vitality

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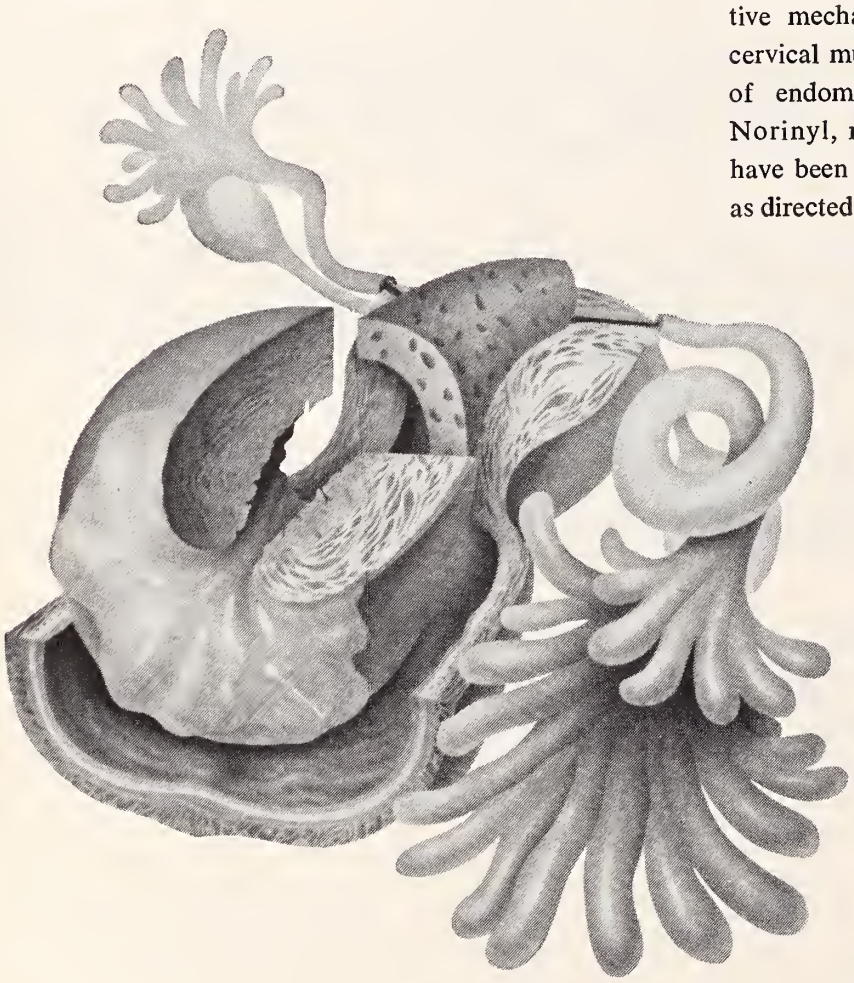
no unplanned pregnancies

Norinyl provides multiple action for maximum assurance of success. It does not depend on ovulation inhibition alone for contraceptive effectiveness. The mechanism of action of combined hormonal therapy results in ovulation inhibition reinforced by other protective mechanisms, including a hostile cervical mucus[1-13] and an acceleration of endometrial changes.[1-3,7-16] With Norinyl, no unplanned pregnancies have been reported to date when used as directed.



plus important supportive benefits that help her through those critical early months of oral contraception

low incidence of side effects

Low incidence of BTB and spotting, nausea and amenorrhea tends to minimize side effect problems and increases patient cooperation.

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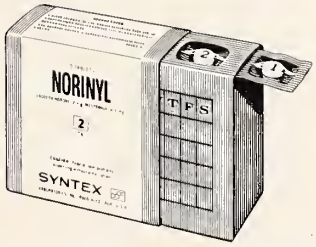
An unbreakable "confusionproof" package makes it easy to adhere to prescribed dosage schedule: individually sealed tablets numbered from 1 through 20 *plus* monthly calendar record enables patient to double-check dosage intake by day and corresponding tablet number.



Contraindications: Thrombophlebitis or pulmonary embolism (current or past). Existing evidence does not support a causal relationship between use of Norinyl and development of thromboembolism. While a study which was conducted does not resolve definitively the possible etiologic relationship between progestational agents and intravascular clotting, it tends to confirm the findings of the Ad Hoc Advisory Committee appointed by the Food and Drug Administration to review this possibility. Cardiac, renal or hepatic dysfunction. Carcinoma of the breast or genital tract. Patients with a history of psychic depression should be carefully studied and the drug discontinued if depression recurs to marked degree. Patients with a history of cerebral vascular accident.

Warning: Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn.

Precautions: By May 1963, experience with norethindrone 2 mg.—mestranol 0.1 mg. had extended over 24 months. Through miscalculation, omission or error in taking the recommended dosage of Norinyl, pregnancy may result. If regular menses fail to appear and treatment schedule has not been adhered to, or if patient misses two menstrual periods, possibility of pregnancy should be resolved before resuming Norinyl. If pregnancy is established, Norinyl should be discontinued during period of gestation since virilization of the female fetus has been reported with oral use of progestational agents or estrogen. When lactation is desired, withhold Norinyl until nursing needs are established. Existing uterine fibroids may increase in size. In metabolic or endocrine disorders, careful clinical preevaluation is indicated. A few patients without evidence of hyperthyroidism had elevated serum protein-bound iodine levels, which in the light of present knowledge, does not necessarily imply hyperthyroidism. Protein-bound iodine increased following estrogen administration. Bromsulphalein retention has occurred in up to 25% of patients without evidence of hepatic dysfunction. Studies from 24-hour urine collections have shown an increase in aldosterone and 17-ketosteroids and decrease in 17-hydroxycorticoid levels. Thus, Norinyl should be discontinued prior to and during thyroid, liver or adrenal function tests. Because progestational agents may cause fluid retention, conditions such as epilepsy, migraine and asthma require careful observation. Thus far no deleterious effect on pituitary, ovarian or adrenal function has been noted; however, long-range possible effect on these and other organs must await more prolonged observation. Norinyl should be used with caution in patients with bone, renal or any disease involving calcium or phosphorus metabolism.

Side Effects: Intermenstrual bleeding; amenorrhea; symptoms resembling early pregnancy, such as nausea, breast engorgement or enlargement, chloasma and minor degree of fluid retention (if these should occur and patient has not strictly adhered to medication plan, she should be tested for pregnancy); weight gain; subjective complaints such as headache, dizziness, nervousness, irritability; in a few patients libido was increased. In a total of 3,090 patients, 2.2% discontinued medication because of nausea.

NOTE: See sections on contraindications and precautions for possible side effects on other organ systems.

Dosage and Administration: One Norinyl tablet orally for 20 days, commencing on day 5 through and including day 24 of the menstrual cycle. (Day 1 is the first day of menstrual bleeding.)

Availability: Dispensers of 20 and 60 tablets; bottles of 100.

References: **1.** Council on Drugs. JAMA 187:664 (Feb. 29) 1964. **2.** Bryans, F. E.: Canad Med Ass J 92:287 (Feb. 6) 1965. **3.** Goldzieher, J. W.: Med Clin N Amer 48:529 (Mar.) 1964. **4.** Cohen, M. R.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965. **5.** Hammond, D. O.: Ibid. **6.** Rice-Wray, E., Goldzieher, J. W., and Aranda-Rosell, A.: Fertil Steril 14:402 (Jul.-Aug.) 1963. **7.** Goldzieher, J. W., Moses, L. E., and Ellis, L. T.: JAMA 180:359 (May 5) 1962. **8.** Kempers, R. D.: GP 29:88 (Jan.) 1964. **9.** Tyler, E. T.: JAMA 187:562 (Feb. 22) 1964. **10.** Rudel, H. W., Martinez-Manautou, J., and Maqueo-Topete, M.: Fertil Steril 16:158 (Mar.-Apr.) 1965. **11.** Flowers, C. E., Jr.: N Carolina Med J 25:139 (Apr.) 1964. **12.** Goldzieher, J. W.: Appl Ther 6:503 (June) 1964. **13.** The Control of Fertility. Report adopted by the Committee on Human Reproduction of the American Medical Association. JAMA 194:462 (Oct. 25) 1965. **14.** Flowers, C. E., Jr.: JAMA 188:1115 (June 29) 1964. **15.** Merritt, R. I.: Appl Ther 6:427 (May) 1964. **16.** Newland, D. O.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965.

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This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

MONTH IN WASHINGTON

WASHINGTON, D.C.—High on the list of health legislation to be considered by the new Congress convening Jan. 10 are proposals to amend both the medicare and medicaid programs.

PROPOSED MEDICARE AMENDMENTS would extend the program to the disabled, include podiatrists' services, add outpatient drugs to Plan B, and authorize that billing for services of hospital-based physician specialists be put back under hospitals.

SEN. RUSSELL B. LONG, (D., La.), chairman of the Senate Finance Committee which handles medicare and medicaid legislation, is pushing a proposal designed to get physicians to prescribe drugs by generic terms for patients under federally-aided medical programs. Such an amendment died in a conference committee in the final days of the last Congress.

AMENDMENTS to limit federal expenditures under medicaid (Title XIX) are expected to get early consideration by the House Ways and Means Committee. The committee reached agreement on such legislation shortly before adjournment last year, but it was too late to get it through Congress.

ONE OF THE final pieces of legislation passed by Congress in 1966 authorizes liberalization of the Keogh law under which physicians get a tax break for savings put in qualified pension plans. The full amount of the $2,500 annual maximum was made tax deductible. Only half of the amount was tax deductible under the original law.

OTHER health legislation approved by Congress in 1966 includes:

GROUP PRACTICE—authorizes federal mortgage guarantees for construction of non-profit group practice facilities.

HEALTH SERVICES—authorizes the Office of Economic Opportunity (anti-poverty) to make grants for comprehensive health services programs, including birth control.

PUBLIC HEALTH—authorizes 1) $145 million, one-year extension of PHS programs, including $125 million for project grants for categorical programs. States and the PHS are given greater flexibility in spending the money among the various categories and including other "public health" projects; 2) extends the federal-aid vaccination program for three years; 3) provides for family health services for migratory workers.

AIR POLLUTION—authorizes a three-year, $186 million extension of the federal anti-air pollution program and provides broader authority for air pollution control activities by localities.

Continued on page 1420.

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*Schiller, I. W., and Lowell, F. C.: New England J. Med. 261:478, 1959.

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Precautions: Until the patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.

Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability, or excitement may be encountered.

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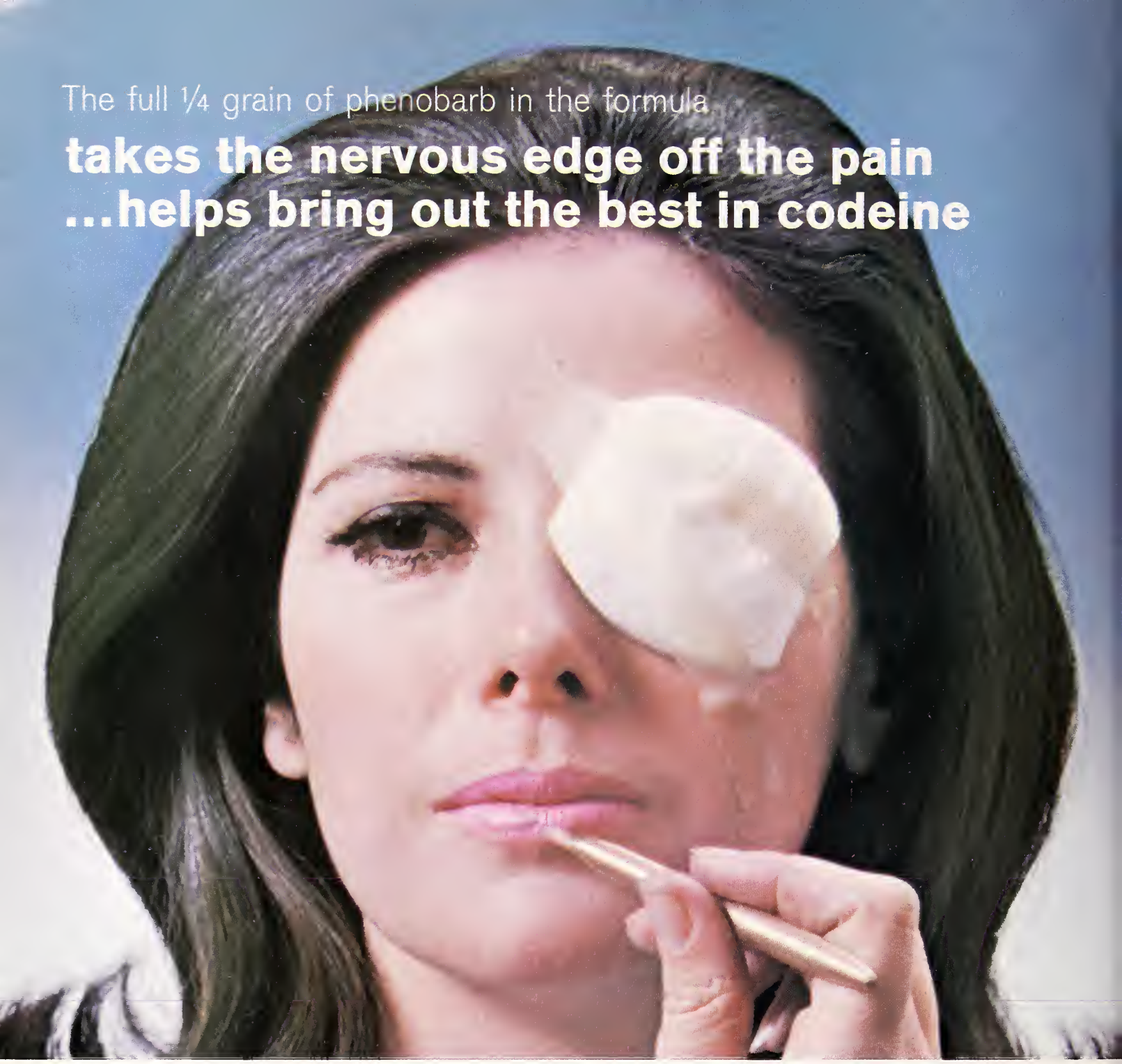

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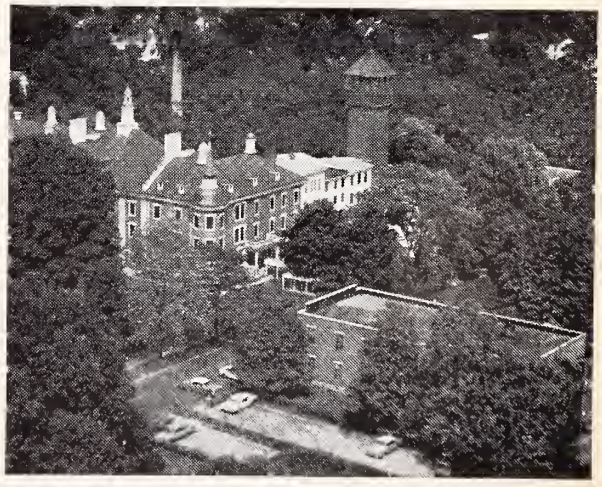

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WATER POLLUTION—authorizes a $3.7 billion, four-year program for cleaning the nation's waterways. It includes initiation of a massive program for combating pollution in major water basins.

CHILD CARE—prohibits sale of toys containing hazardous substances and strengthens existing law covering household hazardous substances; does not contain a disputed provision covering children's aspirin and other drug controls in the original legislation.

NARCOTICS—permits addicts charged with non-violent crimes to choose hospital commitment instead of trial, if the authorities agree, or could be sentenced after trial to hospitals for rehabilitation.

PACKAGING—requires that over-the-counter drugs and grocery products bear labels clearly showing the contents, quantity and manufacturer.

MENTAL HEALTH—amends original law to provide grants to assist in the establishment and initial operation of community mental health centers.

RESEARCH LABORATORY ANIMALS—provides for federal regulations covering transportation, purchase, sale, housing, care, handling and treatment of such animals.

MILITARY MEDICARE—amends existing law to provide for out-patient care in a physician's office and to include retired reservists and their dependents.

ALLIED HEALTH PROFESSIONS—authorizes $105 million for a three-year program to train more medical technicians, therapists and other allied health workers.

GOVERNMENT LAUNCHES ALCOHOLISM FIGHT

THE federal government has launched an extensive program to control and prevent alcoholism.

AS INITIAL STEPS, Health, Education and Welfare Director John W. Gardner established a National Center for the Prevention and Control of Alcoholism and appointed an 18-member National Advisory Committee on Alcoholism.

IN ANNOUNCING the program, Gardner stated its two major aims:

1) The immediate goal of making the best treatment and rehabilitation services available to those who need them now— through both the stimulation of existing resources and the development of new manpower and facilities.

2) The long-range goal of developing effective, practical, and acceptable methods of preventing alcoholism and excessive drinking in all their destructive forms and developing improved therapeutic techniques.

MILTON SILVERMAN, special assistant to the HEW assistant secretary for Health and Scientific Affairs, was named coordinator of the program and executive secretary of the advisory committee.

THE NATIONAL CENTER will be active in a number of major areas including: basic research, clinical research, education and prevention, consultation and training and support of local programs.

Continued

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"IT WILL encourage and support alcohol research in universities and research centers and it will also conduct studies in its own laboratories," Gardner said. "It will not provide treatment for alcoholics, but will concentrate on the support of research, training, and control programs.

"WE REALIZE that a program of this kind cannot stand alone. It needs widespread public understanding and support. We will work with organizations and institutions already making great contributions to the prevention and control of alcoholism. Our objective, in brief, is to mobilize public and professional efforts on the scale necessary to overcome the blight of alcoholism."

Utilization Review In Extended Care Facilities

Major activity in the medical care program for the aged is now concerned with certification of extended care facilities (nursing homes) whose participation under PL 89-97 will become effective January 1, 1967.

The Indiana State Board of Health is currently surveying facilities which have made application to determine degrees of compliance with statutory provisions and related regulations applying to nursing homes. Recommendations for certification, based on survey findings, will then be made to the Social Security Administration.

As in all other phases of the program, the physician is the "key individual" in organizational aspects of the ECF certification activity.

He is concerned in a major regard in utilization review committees which must be established for each facility. As with hospitals, ECF utilization review committees *must include at least two physicians as members.*

As has been reported previously, UR committees may be established on a community-wide basis where feasible. In other words, the same committee can serve several homes. In populous areas the community-based UR committee could be confined to one county. In less populous areas, the committee might service, perhaps, two or three counties.

At least one county medical society already has undertaken utilization review activities for its entire area, and others may be expected to follow this course of action.

UR committees already established for certified hospitals may provide the nucleus in utilization review programs for extended care facilities.

Community-based utilization review committees serving several extended care facilities will provide uniformity of operational procedures and will do much to assure high quality care for beneficiaries of PL 89-97.

against the usual gram-negative urinary pathogens

Why use five...where one will do?

In a recent 217-patient hospital study,[1] urinary tract infections were treated with a variety of widely prescribed antimicrobial agents including: a sulfonamide (40 patients), chloramphenicol (20 patients), nitrofurantoin (33 patients), nalidixic acid (30 patients), tetracycline (27 patients), colistimethate sodium (22 patients)... and 2 combinations of 5 agents each (45 patients). The 2 combinations were selected to afford maximal theoretical antibacterial coverage against the usual urinary pathogens. They were (1) tetracycline, chloramphenicol, nitrofurantoin, ristocetin and polymyxin B; and (2) tetracycline, chloramphenicol, erythromycin, nitrofurantoin and colistimethate sodium.

This clinical study shows that the two combinations of antibiotics were not superior to some of their single components. The authors point out that antibiotic antagonism often negates theoretical advantages of multiple therapy. Coly-Mycin Injectable (colistimethate sodium) was one of the single components that was shown to be equal to the combinations and eradicated bacteriuria in two-thirds of the patients.

Theoretical choice of multiple antibacterial therapy has been shown to be no more effective than one well-chosen agent which also offers least patient exposure to possible side reactions, toxicities, allergic manifestations and higher drug costs.

1. McCabe, W. R., and Jackson, G. G.: New England J. Med. 272:1037, 1965.

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Indications: Especially indicated for the treatment of severe acute and resistant chronic urinary tract infections due to sensitive strains of gram-negative organisms. Also indicated in respiratory tract, surgical, wound and burn infections and in septicemia due to sensitive organisms. Particularly indicated when any of these infections are caused by sensitive strains of *Pseudomonas aeruginosa.*

Adverse Reactions: Occasional reactions such as circumoral paresthesias, tingling of the extremities, pruritus, vertigo or dizziness may occur. Reduction of dosage may alleviate symptoms. Therapy need not be discontinued, but such patients should be observed with extra care.

Warning: Patients should be cautioned not to drive vehicles or use hazardous machinery while on therapy.

Precautions: In cases of impaired or suspected renal impairment, use with greater caution and reduce dosage in proportion to extent of impairment. Transient elevations of BUN have been reported. As a routine precaution, appropriate blood studies should, therefore, be made during prolonged therapy.

As with all polypeptides, the possibility of muscular weakness, including apnea, due to inadvertent overdosage or normal dosage in the presence of impaired renal function, should not be overlooked. In cases of apnea, medication should be promptly discontinued and assisted respiration given until serum levels fall and normal breathing is restored.

Other antibiotics, such as kanamycin, streptomycin, dihydrostreptomycin, polymyxin, and neomycin, may also have varying neurotoxic or nephrotoxic potential. They should be used with great caution concomitantly with Coly-Mycin Injectable (colistimethate sodium).

For deep intramuscular injection only.

Dosage: By the I.M. route only, in 2 to 4 divided doses ranging from 1.5 to 5 mg./Kg./day (0.7 mg. to 2.3 mg./lb./day). Average adult dose is 2.5 mg./Kg./day (1.1 mg./lb./day). In the presence of bacteremia, septicemia, or other serious infection, greater than average doses may be required; however, maximum daily doses should not exceed 5 mg./Kg. (2.3 mg./lb.) where renal function is normal.

Not recommended against Proteus.

Colistin is also available (as colistin sulfate) in: Coly-Mycin® Pediatric for Oral Suspension (not for systemic use), and Coly-Mycin® Otic with Neomycin and Hydrocortisone.

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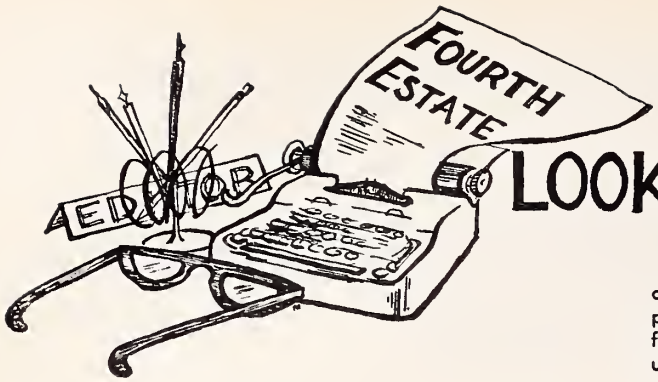


LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

The Hoosier Day

State Shortage of GPs Serious

By Frank White

How to obtain more resident physicians, especially in smaller communities, and how to get more general practitioners, or family doctors, instead of specialists, is an acute problem in Indiana.

A proposal to build a second medical university, perhaps costing initially as much as $30 million dollars is far advanced. Were it to be built to supplement the Indiana University Medical School, a possible $18 million dollars to help, might be obtained from Federal sources.

Campaigns of magnitude have been waged for a second medical school in Elkhart, South Bend in connection with Notre Dame, Evansville and Muncie. The movement for such a medical school is far advanced. A Legislative Advisory Committee, Sub-Committee, headed by Dr. Walter J. Beneville, of Jeffersonville, has made its recommendation. Dr. Beneville is a graduate of the National College of Chiropractic, and his committee has heard many witnesses.

The committee recommended that the proposed new medical college be located at Ball State University at Muncie. This recommendation has not stilled the vigorous bids made by other cities for the school.

The American Medical Association, with its strong Indiana component, asks the question whether there is really a shortage of physicians, or is it a matter of distribution of existing doctors. Indiana University Medical School graduates about 150 doctors a year.

An editorial in the *Martinsville Reporter,* raises a question of whether the bottleneck may be other than lack of school facilities. It said, "The cause of Indiana doctor shortage has never been lack of school facilities. The state has 2.5% of the national population, and trains 4.5% of its doctors.

"The trouble is, physicians do not stay in Indiana after they complete medical school. What we lack is not medical school facilities, but training hospital facilities — internships."

Three Indiana University professors made a year-long study of the "Growth and Change in Indiana University." They came up with the following statistics on internships. It said: "The number of available internships and residencies in Indiana is especially low. In 1965 there were only 383 doctor residencies in Indiana and 201 of these were at the I. U. Medical Center.

"By way of contrast, Illinois offered 2,010, Michigan 1,945, Ohio 2,251 and Kentucky 423. As for internships in the fall of 1965, Indiana had only 130, while Illinois had 757, Michigan 562, Ohio 812 and Kentucky 117."

It is an established fact that graduate doctors usually locate in communities where they finish internship.

There is an alternate proposal that will come before the state legislature five months hence. It may be called the Indiana University plan, advanced by I. U. President Elvis J. Stahr.

This plan would permit premedical training of students to be carried on in different higher educational institutions of the state. The finishing training would be carried on by Indiana University Medical School. The plan would also widen internships to other cities of the state. Dr. Stahr has pointed out such a plan would enable practicing physicians to keep in touch with academic developments and produce more doctors sooner, than building a new medical school. — *New Albany Tribune,* Sept. 1, 1966.

Detention Is An Urgent Need

Regardless of other aspects of the departure of Dr. Joseph Geyer from Silvercrest hospital, the public can take heart from one fact — the state has confirmed long-delayed plans for a detention section there.

While not the only need at the big hospital on the hill, it is one which has major significance for members of the general public. In many ways, a detention section is as important to public health as the Tine tests given school children or the x-rays taken during visits of the state mobile unit.

Public officials and those concerned with public health locally long have cast despairing eyes on the many tuberculosis cases roaming the streets of the Tri-County area. Actually, the number of active TB cases which are not being treated is frightening.

Some persons with the disease do not know it. They have not had an adequate physical examination for years, perhaps, and have failed to take advantage of the free x-ray service offered by the state and the Floyd

County Tuberculosis Association.

These are a matter for proper concern by public health agencies. Despite extensive newspaper publicity, many citizens continue to disregard the ever-present threat of TB, and fail to take advantage of the services offered them.

A far more active danger, however, are the persons who know that they have the disease. They know that they should be undergoing treatment. They know that they may infect others — and they don't give a damn.

Quite a few have been under treatment at Silvercrest, but have rebelled at hospital routine and boredom, and simply walked away. Exactly how many are in this category is uncertain. Public health workers say the number is high, but they can supply no accurate figures. Silvercrest either can't or won't provide the answer.

Persons who have active cases of tuberculosis must be isolated from the community at large for treatment, or the disease, already at high incidence in this area, will lay low thousands more of us.

Most persons who become ill seek treatment. For those who do not, or those who refuse to consider the common good, detention is the only answer. The circuit court here, for instance, orders an average of eight persons a year to the detention section of Rockville state hospital.

And this is only one part of the problem. We have, as one facet of the situation, the fact that humanity demands that we treat the ill among the population of our penal institutions.

They should be treated at the facility which can best handle their particular disease or infirmity. If it should be tuberculosis or another chest disease, the proper place for treatment is a state tuberculosis and chest disease hospital.

There is, for instance, one state prisoner who has been in need of chest surgery for some time. He was sent to Silvercrest — and walked away before the operation could be performed.

State penal authorities want this man's serious illness to be treated surgically. But detention facilities do not exist here and are inadequate at Rockville.

One of the urgent matters which will come before the Legislature when it convenes in January will be a request for funds for physical changes at Silvercrest. We hope our lawmakers move with dispatch to accomplish a task which should have been done years ago. — *New Albany Tribune*, Sept. 14, 1966.

Indiana's Medical School

Recently we had an opportunity to talk with a man who has had several years of experience at the I. U. Medical Center. He was asked what he thought of the proposal to build a second school of medicine in the state.

"Those who think we should have another medical school in Indiana should come out to West Michigan Street and look around, he said. Instead of thinking about a second school, the one we have should have stronger support," was his contention.

Then he went through the various departments, this one strong, that one weak or inadequate. He called attention to the difficulty and costs of assembling a new faculty, the cost of up-to-date equipment and facilities for another medical school, the advantages of the present Medical Center in having hospital facilities and patients.

It would be extremely foolish, in his view, to start another school, for many reasons.

The urgent need, now, is to look after the one we have with better equipment and an enlarged budget.

His analysis made so much sense, that we were convinced that he was right.

Should we take one man's opinion as against the study and report of a commission or committee which has recommended a second school? The soundness of an opinion is not to be determined by the number of votes, but by the facts. Often it is difficult to decide between conflicting opinions. Sometimes, however, the answer is obvious, and no amount of talk should change an obvious and sound judgment.

It appears quite obvious that one strong medical school in Indiana is much to be preferred to two relatively weak ones.—*Martinsville Reporter*, Sept. 24, 1966.

Onward and Downward With Socialism

"I believe deeply in the Health Service. But it's a good Health Service I believe in, and you can't have that on the cheap."

So says a young British doctor, who is thinking of quitting his nation's program of "free" health care and emigrating, presumably to the U.S. His disenchantment points up the extent to which reality has intruded into a socialist dream.

When Britain's National Health Service was set up 18 years ago, its founders had high aims. Not only was everyone, young and old, to receive free medical and hospital services, whether they could afford to pay for them or not. In addition, the quality of those services was expected to sharply improve. Unfortunately, things haven't worked out quite that way.

Costs of the NHS quickly soared beyond initial estimates, so far beyond that some benefits had to be reduced. Outlays nonetheless remained heavy, contributing to those budget deficits that have much to do with the present precarious state of Britain's economy and its currency.

NHS operating expenses, moreover, left no money for new and improved hospitals, and facilities have continued to deteriorate. Nor were there funds to raise salaries to levels young doctors considered adequate; estimates are that emigration each year costs Britain the equivalent of one-fifth to one-third of its medical school graduates.

Though the Government now says it plans to build some hospitals and expand medical schools, it's apparent that a socialist vision has been blurred by some harsh economics. After all, no nation's resources are limitless—a

point also worth remembering on the opposite side of the Atlantic.—*Wall Street Journal*, Sept. 21, 1966.

The Promise Of Life

Indiana is proud of the work of the team of Indiana University surgeons who have developed a total artificial heart due in the near future for experimentation in a human being.

The recent success of similar experiments justifies hope for a breakthrough in heart surgery that will extend the useful lives of untold numbers of men, women and children.

Surgeons and scientists do not like to call such works miracles, but in the minds of most men who realize how helpless most victims of serious heart disease are today, they are miracles. Too many young, promising lives have been cut short and too many mature, valuable lives have been doomed by this "No. 1 killer."

Indiana, America and all the world will watch future developments in the work of Dr. Harris B. Shumacker Jr., chairman of the I.U. surgery department, his associate, Dr. Winton H. Burns, and the other earnest researchers co-operating in this significant project.

We wish them Godspeed and success.—*Indianapolis Star*, Oct. 9, 1966.

Solving The State Doctor Shortage

Building another medical school is not the primary way to get more doctors for Indiana, as the president of Indiana university has so well pointed out.

Our trouble is not that we do not have enough medical students, but that we do not have enough medical graduates interning in Indiana hospitals or in residency training here.

During a seven-year period ending in 1964, Indiana's population increased only six percent while the size of the first year medical class at I.U. was being enlarged by 37%, the Indiana university report shows.

Indiana taxpayers already are supporting far more than their proportionate share of medical schools upon the basis of population. But unfortunately we are behind all of our bordering states in residency training and less than half of our medical graduates are interning in Indiana.

Since most doctors practice medicine in the state where they complete their training, the most sensible way to solve the doctor shortage is to expand the number of internships and residencies available to medical school graduates. This is where the emphasis should be put by the next General Assembly.—*Logansport Pharos-Tribune & Press*, Oct. 2, 1966.

Aroused Electorate May Develop Muscles

Good ideas oftentimes never get off the drawing boards.

Frequently, enthusiasm wanes shortly after the idea is presented, about the same time there comes a realization of the work that will be involved.

However, that does not appear to be the fate for a proposal by Dr. Weston Heinrich, president of the Medical Education Development Committee of Evansville.

Last Monday he suggested a letter writing campaign to state legislators, which does not have to deal solely with obtaining the state's second medical school.

"I've been told Southern Indiana has to sit still because it has no political muscle, and we are going to stir things up a little," Dr. Heinrich said.

"Evansville hasn't had one thing of the state legislature in 35 years."

The suggestion has stirred things up in Evansville already. At least one PTA organization has launched a letter writing campaign. And one East Side minister devoted part of his sermon Sunday to outlining the goals of MEDCOE, the needs of Southern Indiana and urging his parishioners to write letters as suggested by Dr. Heinrich.

Evansville and Southern Indiana have good cause to be "stirred up." And the problem is not only the issue of the medical school, although that may have been the final blow.

Southern Indiana has a list of grievances with the state, topped by lack of adequate highways and the medical school issue.

When an unlikely site (Ball State University) was selected over Evansville, there were a lot of people who wanted to know why. Adequate reasons have not been forthcoming.

Ball State was a most unlikely choice because of its proximity to the state's only other medical school at Indianapolis. Why should both of Indiana's medical schools be squeezed into a radius of about 60 miles when there is no medical school within 140 miles of Evansville?

The issue apparently isn't settled yet, but Ball State did get the initial nod.

Perhaps it takes a disappointment like that to get people stirred up, and visions of an educational complex in the Evansville area added fuel to the fire.

Whatever the outcome of the letter writing campaign at least state officials will get the idea that Southern Indiana is tired of being overlooked. And if they don't respond, a newly aroused electorate might suddenly develop its political muscle.—*The Evansville Courier*, Oct. 17, 1966.

Doctors Serve Here

Word from the Indiana State Medical Association annual convention at French Lick that Dr. G. O. Larson of LaPorte was chosen president-elect for 1967 prompts the observation that this community is home for a number of professional men in the field of health who give of their time and talent to community and state-wide human welfare programs. These people are to be commended for the interest they take in other-than-professional matters.

Dr. Larson will be serving in a state position, of course, but his record for community service here is an impressive one. For 17 years he served on the LaPorte school board, and after that service he tackled the difficult job of heading the county school reorgani-

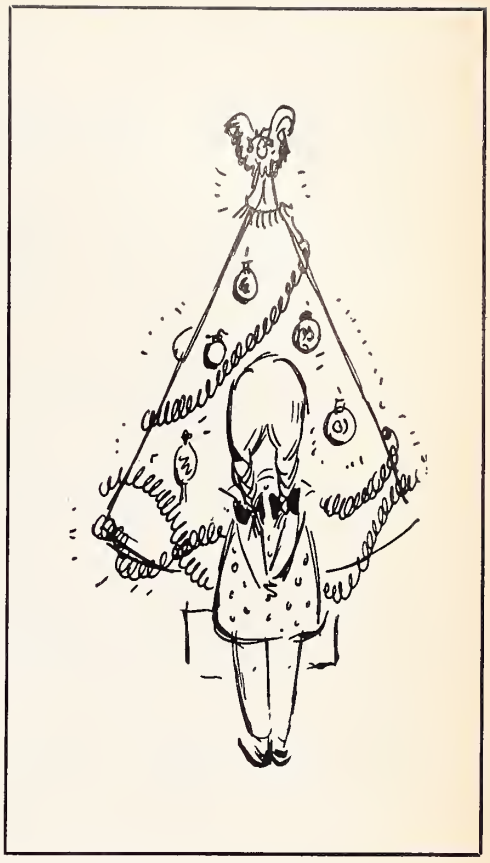
zation commission. In Boy Scouts, United Fund, YMCA and many other civic activities he has carried part of the load over the years.

He is an outstanding example of other-than-professional service by a professional man, but there are a number of others here. We can tick them off rapidly. Dr. J. C. Richter is a former YMCA board president and very active in the "Y"; prominent in United Fund work, among other endeavors. Dr. E. C. Mueller is a park board member and active in United Fund. Dr. S. S. Philbrook is a LaPorte community school board member and closely involved in other civic affairs.

Dr. J. E. Magnuson is a past president of the Indiana State Dental Association and has been prominent in Boy Scout work, to mention one other endeavor of his. He is also a member of the State Radiation Control Advisory commission. Dr. Barbara Backer is very active in Indiana and local heart association affairs and has just been appointed to the county health department board which will come into existence Jan. 1. Dr. R. W. Kepler is head of the county Red Cross chapter here and has been active in church affairs.

The list is by no means exhaustive, but it does give an idea of the devotion of many professional people here to worthwhile causes which must have volunteer effort and sacrifice in order to succeed or even to stay alive.

It is seldom easy for a doctor or dentist to find time for community activities, but LaPorte's coterie of people devoted to health matters have been and are unusually unselfish in their devotion to the general welfare. —*LaPorte Herald-Argus,* Oct. 17, 1966. ◄



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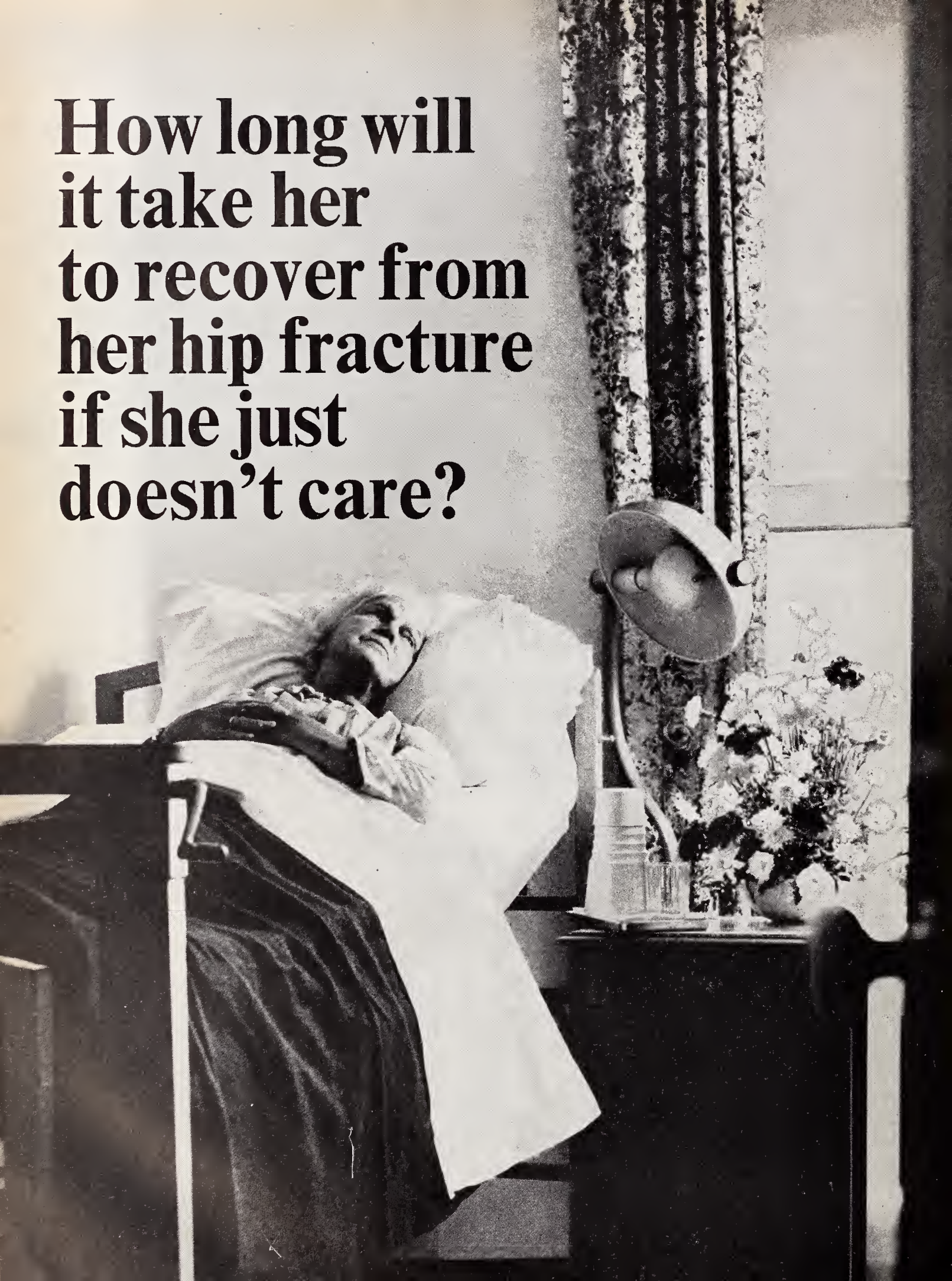

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The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Supervised by The COUNCIL

Volume 59 — December 1966 — Number 12

A rare and serious complication of massive ascites is reported and its management discussed. Infusion of aspirated ascitic fluid as recommended by Lempke is proposed to prevent perforation of the hernial sac and resulting loss of protein-containing fluid.

Spontaneous Rupture of an Umbilical Hernia Due to Massive Ascites

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THE presence of an umbilical hernia is common in patients with massive ascites due to chronic liver disease but spontaneous perforation of the hernia is rare. This paper will discuss such a patient and review the treatment of others with this condition.

Case Report

A 55-year-old housewife was admitted to Robert Long Hospital on February 11, 1961, because of massive ascites and an infected, ulcerated area over a large umbilical hernia. She had not been well since 1956 when she had had severe hematemesis, requiring transfusion. The hematemesis recurred in 1958. She was admitted again in 1959 with jaundice, hepatosplenomegaly and esophageal varices. Exploratory laparotomy was performed and her portal venous pressure was found to be 45 cm. of saline.

A portavenogram demonstrated the esophageal varices and many collateral venous channels but did not demonstrate any flow through the portal vein. Numerous stones were removed from the common bile duct and cholecystectomy and transduodenal sphincterotomy performed. In the following months, her liver function improved, but ascites became an increasingly severe problem. Because of this, portal decompression was recommended, but refused by the patient. From 1959 until the present admission she was on constant dietary management and medication. In addition, three hospital admissions were necessary for control of the ascites.

At the time of this admission, there was a hernia at the site of her previous surgical incision and an umbilical hernia which measured 10 cm. in diameter with several ulcerated areas in the attenuated, overlying skin.

Laboratory studies included a hemoglobin level of 10.1 Gm. percent. The white blood cell count was 6,000 per mm^3. The total bilirubin was 0.9 mg. percent with an indirect fraction of 0.6 and a direct of 0.3. The cephalin flocculation was 4+ at 24 hours. The total protein was 5.6 Gm. percent with 2.8 Gm. percent each of albumin and globulin. The alkaline phosphatase was 2.7 B.L. units and the prothrombin time was 31.5%.

Intravenous infusion of the ascitic fluid was begun in an effort to prevent perforation of the umbilical hernia. On the third day of this program, hematemesis occurred. The ascitic fluid infusion was stopped and she was transfused with 2,500 ml. of blood. The bleeding ceased, but the ascitic fluid began to reaccumulate. On the evening of February 22, she vomited and with this effort, the um-

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bilical hernia ruptured through the overlying skin with an immediate estimated loss of 5,000 ml. of straw-colored fluid. This event did not result in hypotension or in any apparent distress, except for some anxiety. Parenteral antibiotics and intravenous albumin solutions were administered. Several hours later, the umbilical and the ventral hernias were repaired under local anesthesia. The repairs healed well and she was discharged on her usual regimen.

Four months later she was readmitted in a moribund condition with a temperature of 106°F. and a blood pressure of 55/30. According to the family, fluid had begun to leak from the scar overlying the umbilical hernia repair two weeks before. A paracentesis had been performed and the ascitic leak slowed, but was replaced by a small amount of purulent material. She then became febrile and deteriorated to the state at the time of admission. She died six days after admission, and postmortem examination confirmed the cirrhosis and demonstrated acute fibrinous peritonitis due to Staphylococcus aureus.

Discussion

Reported instances of spontaneous perforation of an umbilical hernia due to massive ascites are rare. The 12 reported cases we found are listed in Table I. Baron[1] reported three persons and Flood[2] reported five persons with this condition. Eisenberg[3], Lerner[4], Tracy[5] and Yonemoto[6] each reported one case of perforation of the umbilicus due to massive ascites. Seven of the 12 patients died; the causes of death are listed in Table II. As may be noted, peritonitis was the cause of death in three, renal insufficiency in one and hematemesis in one. One person died of pulmonary edema and one of peritonitis and renal insufficiency. The time from perforation to death varied from three to 27 days.

When these seven patients are compared with the six survivors, there is no obvious distinguishing feature between the two groups. In both groups, some of the perforations were dramatic with sudden, almost complete drainage of the ascitic fluid while others resulted in slow, intermittent leakage of ascitic fluid from small openings in the skin. In both groups, some of the perforations were the cause of the hospital admission while others occurred in patients already hospitalized. The laboratory data are not available in all of these cases but when available, there are no obvious distinguishing blood chemical abnormalities reflecting differences in the severity of the underlying hepatic disease. The ages of the survivors (33-70) are no different from the ages of those who died (31-70). The treatment of these patients was fairly uniform. All received antibiotics and intravenous fluids, usually albumin-containing solutions.

The outcome in the surviving group is interesting. Our patient died in four months due to a recurrence of ascitic leakage and resultant peritonitis. The patient reported by Yonemoto died of a bleeding hepatoma five months after hernia repair. One patient reported by Baron died in hepatic coma nine months after hernia repair; there was no postoperative observation in Baron's second case. The case reported by Lerner was followed for only one month. This leaves only one known long-term survivor, the patient reported by Tracy and associates. In this 45-year-old man, a portacaval shunt was performed on the third day after spontaneous perforation of an umbilical hernia and the hernia was not repaired. Three years later he continued to do well.

From this review of reported cases, it is not possible to correlate survival with any specific feature — not the

PATIENTS WITH SPONTANEOUS PERFORATION OF UMBILICAL HERNIA

Source of Report	Age	Sex	Outcome
Baron	67	M	Survived
Baron	33	F	Survived
Baron	31	F	Died
Eisenberg	70	M	Died
Flood	53	M	Died
Flood	47	M	Died
Flood	45	F	Died
Flood	47	F	Died
Flood	56	M	Died
Lerner	48	M	Survived
Tracy	45	M	Survived
Yonemoto	70	M	Survived

TABLE I

CAUSES OF DEATH

Source	Age	Sex	Cause of Death	Time from Perforation to Death
Baron	31	F	Hematemesis	5 Days
Eisenberg	70	M	Peritonitis	6+ Days
Flood	53	M	Peritonitis	9 Days
Flood	47	M	Renal Insufficiency	13 Days
Flood	45	F	Pulmonary Edema	3 Days
Flood	47	F	Peritonitis, Renal Failure	27 Days
Flood	56	M	Peritonitis	27 Days

TABLE II

suddenness nor completeness with which the ascitic fluid is lost, not any chemical or physical manifestation of the pre-existing liver disease nor any factor in the treatment. Rupture of an umbilical hernia due to ascites is ominous. Rapid loss of a large amount of protein and electrolyte-rich fluid may result in vascular insufficiency, hepatic decompensation or metabolic problems. Slow leakage or rapid drainage may result in peritonitis. Of the 13 reported cases, including ours, there is only one known long-term survivor.

Intravenous infusion of ascitic fluid has been utilized by Lempke[7] and his associates as a means of reducing the risk of surgery in cirrhotic patients with ascites. When spontaneous perforation of a hernia due to ascites seems imminent, intravenous infusion of the ascitic fluid may prevent perforation and permit elective repair of the hernia without the extreme risk imposed by perforation upon the pre-existing hepatic disease. Obviously, such repair will not prevent recurrence of ascites. When conditions permit, therefore, portal-systemic shunting would seem to be the definitive therapy of choice.

Summary

We have reported the 13th patient with spontaneous perforation of an umbilical hernia due to massive ascites from hepatic cirrhosis. Seven of these 13 patients died because of peritonitis or because of the effect of the perforation on the pre-existing hepatic disease. There was only one definite long-term survivor. To avoid this mortality, intravenous infusion of the ascitic fluid is proposed as a useful procedure when such perforation seems imminent. When possible, portal-systemic venous shunting probably is the procedure of choice for long-term survival.

REFERENCES

1. Baron, H. C.: Umbilical Hernia Secondary to Cirrhosis of the Liver, Complications of Surgical Correction, *New Eng. J. Med.* 263:824-828, October 27, 1960.
2. Flood, F. B.: Spontaneous Perforation of the Umbilicus in Laennec's Cirrhosis with Massive Ascites, *New Eng. J. Med.* 264:72-74, January 12, 1961.
3. Eisenberg, M. M., Hoye, S. J.: Spontaneous Perforation of Umbilical Hernia. The Need for Early Herniorrhaphy in Ascites, *AMA Arch. Surg.* 81:514-516, September, 1960.
4. Lerner, S., Rost, M. S.: Spontaneous Abdominal Paracentesis, *JAMA* 170:1310-1311, July 11, 1959.
5. Tracy, G. D., Reeve, T. S., Thomas, I.D., Lucas, N. A.: Spontaneous Umbilical Rupture in Portal Hypertension with Massive Ascites, *Ann. Surg.* 161:623-625, April, 1965.
6. Yonemoto, R. H., Davidson, C. S.: Herniorrhaphy in Cirrhosis of the Liver with Ascites, *New Eng. J. Med.* 255:733-738, October 18, 1956.
7. Lempke, R. E., Kaiser, G. C., King, R. D., King, H.: Autogenous Ascitic Infusion in Management of Cirrhotic Surgical Patient, *JAMA* 183:347-349, February 2, 1963

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God jul och gott uytt ar. (Swedish)

No matter how you spell it, the editor and staff of The Journal wish one and all "A Merry Christmas and a Happy New Year."

Our thanks to Bob Stalcup and Cloyd T. Thompson, executive director of personnel and industrial relations, Citizens Gas & Coke Utility, for making this month's cover available to us. The picture is of a five-generation-old Bible owned by the family of Mr. Thompson.—J.F.S.

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Indianapolis*

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Technical advances have been directed towards finding an efficient way of accurately localizing an excess of radioactivity in the brain. With the development of the more efficient scintillation crystal detector, achievement of better collimation, development of motor-driven scanning devices and camera devices plus the introduction of technically more suitable radiopharmaceuticals, brain scanning has become a simple, everyday procedure. Its accuracy rivals that of the more commonly employed radiologic contrast studies while its simplicity and lack of morbidity surpasses them.[4]

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Blood-Brain Barrier

The physiologic basis of the brain scan is presently incompletely understood. Localization of the intravenously injected radionuclide probably depends mostly upon the blood-brain barrier and the effect of pathological conditions upon this barrier.[1] Ordinarily this barrier is effective in completely preventing or markedly limiting the transfer of all but a few substances from the blood to the extracellular and intracellular space of the brain. The barrier is not an all-or-none phenomenon, but rather seems to be a rate limiting phenomenon. Not only are the more complex molecules excluded from the brain by this phenomenon, but simple electrolytes, colloids and vital dyes are also effectively kept out. Lipoids, lipoid soluble substances, water and glucose pass readily. It is probably of significance that all the useful radio-pharmaceuticals are protein bound in the circulation to a greater or lesser degree. They are, under ordinary circumstances, excluded from the brain tissue.

Areas of normally increased permeability in this barrier include the hypophysis, infundibulum, hypothalamus, pineal, area postrema and choroid plexus. Many conditions alter the blood-brain barrier. Qualitatively, all of these conditions have exactly the same effect, namely to allow a substance that ordinarily is excluded from the brain to penetrate. These pathologic conditions include injury, such as pricking the cerebral substance with a needle, concussion, cerebral hemorrhage, infections, brain tumors, injection of contrast media and x-irradiation. Although each insult will alter the barrier in a more or less characteristic location and degree, the extent of injury to the blood-brain barrier is probably the final determining factor of the amount of uptake of the radionuclide.

Other significant features of a lesion to be detected include:

1) the lesion being extrinsic to the cerebral circulation such as a meningioma or metastasis and therefore not participating in the blood-brain barrier.
2) the neovascularity of a lesion which occurs in subdural hematoma membrane or glioblastoma multiforme.
3) the metabolic activity of the lesion.

At our institution, we employ neohydrin labeled with mercury^{203}. It is useful because it is rapidly cleared from the blood, has a single emission gamma ray and a long physical half-life of 47 days which makes it economical. Its principal disadvantage is that 10% of the dose is retained by the kidneys and excreted with a 28-day half-life. This gives a dosage variously estimated at from 50 to 165 rads to the kidneys. Administration of non-radioactive mercury in the form of 1 cc. of mercuhydrin intramuscularly may reduce the dosage to ⅓ of these

estimates. We follow the protocol of Blau and Bender[2] and use a Picker Magnascanner. The introduction of newer radiopharmaceuticals that have no particulate emission, a shorter half-life and rapid blood clearance, has reduced the patient irradiation and time necessary for scanning. A short list of the clinically useful radionuclides includes ^{99m}Tc as pertechnetate, ^{131}radioiodinated serum albumin, ^{203}Hg or ^{197}Hg Neohydrin, ^{74}As, ^{68}Ga, and polyvinyl pyrolidine-^{131}I.

Scans Highly Accurate

Clinical scans are readily interpretable with a little practice. A testimony to this is the high degree of accuracy achieved at our institution where the resident staff interprets the scan after a very short period of supervision. Although the skill and training required to interpret the radiologic contrast studies are not necessary to read the scan, a sound knowledge of the cerebral anatomy is helpful. Thus the normal scan (Figure 1A and B) will show areas of high activity over areas of normal vascularity, namely the scalp, venous sinuses and musculature.

It is important to compare the scan with the normal skull film (Figure 2) to exclude a lesion in the skull or scalp causing increased activity. Thus a recent burr hole, superficial inflammation or Paget's disease can give localization.

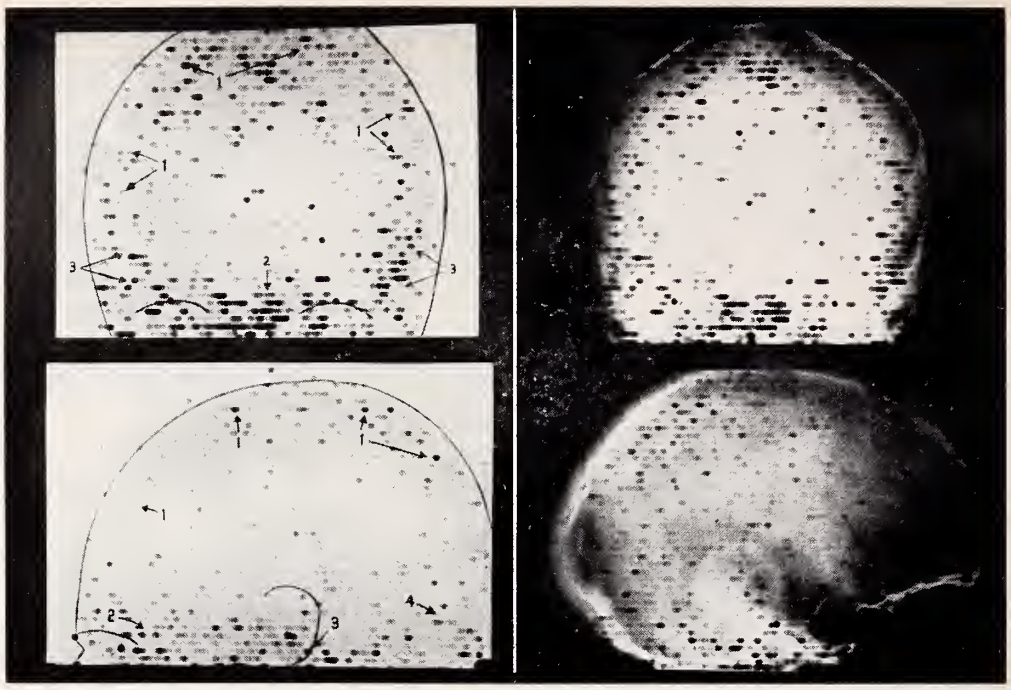

FIGURE 1A AND B

NORMAL brain scan: (1A) Note the accumulation of activity in areas of high vascularity: 1) the scalp and sagittal sinus; 2) the facial muscles and paranasal sinuses; 3) the temporal nuchal musculature; 4) the confluence of the venous sinuses. With a little practice it is simple to pick out the normal anatomy from the landmarks on the scan: the nasion, external canthus and external auditory meatus. (1B): Normal scan superimposed on skull films. By use of the landmarks on the scan, the scan and skull film have been superimposed. An appropriate contrast study may also be used. This provides good anatomic correlation.

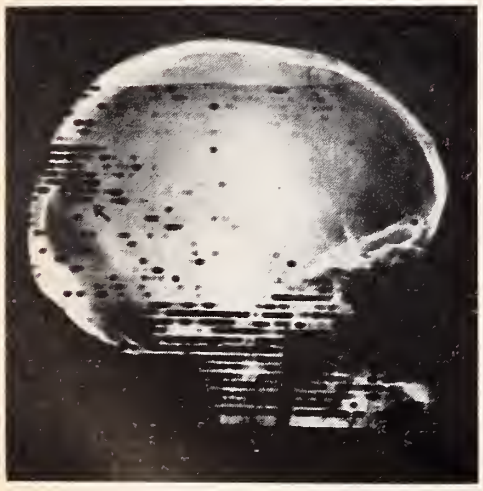

FIGURE 2

CONCENTRATION due to defects in the calvarium: Skull defects such as from a burr hole as shown here, or fibrous dysplasia, Paget's disease and hyperostosis may concentrate the isotopic compound. It is therefore important to compare the scan with the skull film.

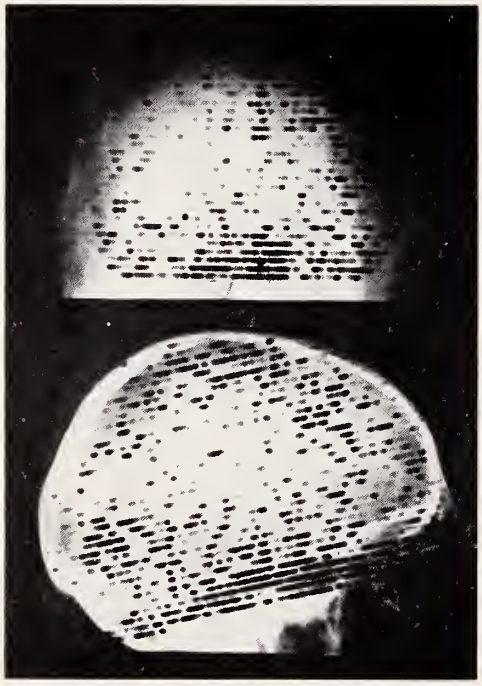

FIGURE 3

SUBDURAL HEMATOMA: The isotopic compound has been shown to concentrate in the membrane of the chronic subdural hematoma more than in the fluid. Subdural hematomata are readily visualized. Characteristically there is thickening of the convexity activity on the frontal scan. The lateral view may appear normal or show what appears to be thickening of the area of the superior sagittal sinus.

FIGURE 4

ABSCESS: the scan may be positive before there are positive angiographic findings. Angiography reflects the subsequent maturation of an abscess, usually after several weeks. The positivity of the scan, however, depends upon the "blood-brain barrier" alterations which occur sooner.

Trauma, such as intracerebral, subdural or extradural hematomas give positive scans. The unilateral subdural hematoma gives a typical asymmetric area of crescentic activity on the frontal view while appearing normal on the lateral view (Figure 3). The activity is probably localized in the membrane and its neovasculature. We have detected intratemporal hematoma consequent to a contrecoup injury.

Inflammation also breaks down the blood-brain barrier. We have had two positive scans in cases of abscess when the angiogram has been negative. Possibly the stage of cerebral cellulitis alters the blood-brain barrier prior to the development of the mature abscess capsule which takes several weeks and is necessary for the changes seen on angiography (Figure 4).

Cerebral vascular accidents will alter the blood-brain barrier about three weeks after the acute episode. Generally, these changes tend to resolve in several weeks. However, severe brain damage causes more persistent physiologic alteration and takes longer to resolve. In general, the area of uptake should become smaller and more discrete upon rescanning in two or three weeks (Figure 5). One should also keep in mind the cerebral arterial distribution since the area of high uptake should correspond to the distribution of the disturbed nutrient artery.

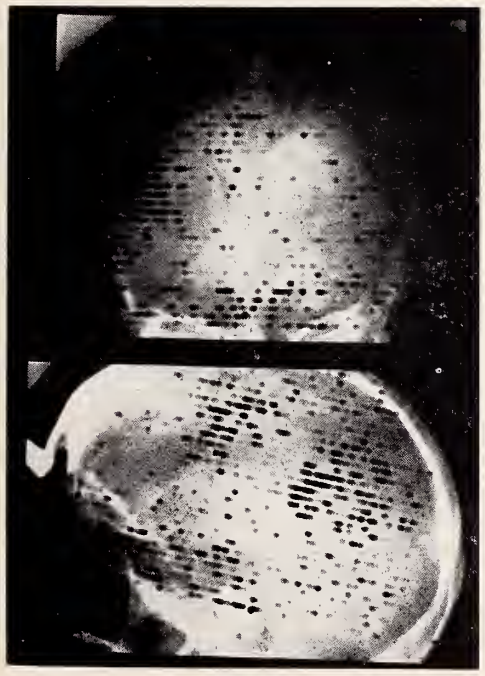

FIGURE 5
CEREBRAL VASCULAR ACCIDENT: accumulation of the radionuclide in an area of cerebral infarction may occur as early as 24 hours following the clinical episode, but characteristically the area of increased activity becomes most positive about three weeks after the acute clinical episode, and then resolves.

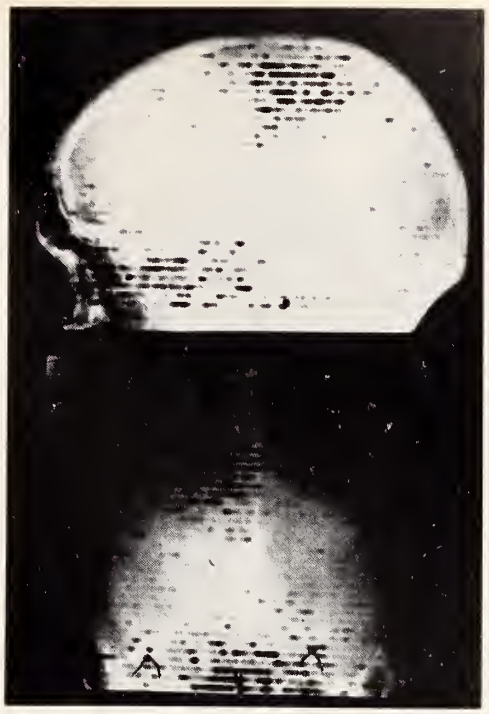

FIGURE 6
PARASAGITTAL MENINGIOMA: note the high activity, sharp round contour and convexity location. The accuracy of the scan in localizing meningiomata is high—probably better than 90%. The scan can detect lesions missed by the angiogram.

Primary intracranial tumors have an avidity for the radionuclide, seemingly in proportion to their degree of anaplasia and neovascularity. Meningiomata are readily localized because they are in reality extrinsic to the blood-brain barrier and highly vascular. They are usually areas of high uptake that are discrete and correspond to their meningeal location (Figure 6).

Glioblastoma multiforme tumors generally have high uptake of the radionuclide. This is presumably due to the well-developed tumor vasculature which it displays. Generally, uptake is high and irregular in outline. When the lesion can be ascertained to cross the corpus callosum in typical butterfly fashion, glioblastoma is highly likely (Figure 7).

The better differentiated gliomas (astrocytomas grade I & II, pontine gliomas) and less vascular tumors (oligodendrogliomas, ependymomas) are less likely to be detected.

Metastatic tumors, because they are usually extrinsic to the blood-brain barrier, are readily detectable. They are the most common cause of more than one discrete lesion. The propensity to localize along the posterior aspect of the Sylvian fissure in the region of the junction of the temporal, parietal, and occipital lobes[3] should be kept in mind (Figure 8).

We have performed over 1,000 scans on a routine clinical basis in the past three years. Our results, based on review of 410 cases, (Table 1) of correct localization of 79% of primary intracranial tumors corresponds with the figure of around 80% frequently found in the literature. Posterior fossa tumors are often said to be less accurately localized and this has been true in our experience. This is probably due to the nature of the more common tumors here since meningiomas or metastasis in the posterior fossa are readily localized. We had nine "false positive" scans in the series of 410 patients reviewed, or 2%. In review of these scans, only one showed the proper criterion for a "positive" scan, namely increased up-

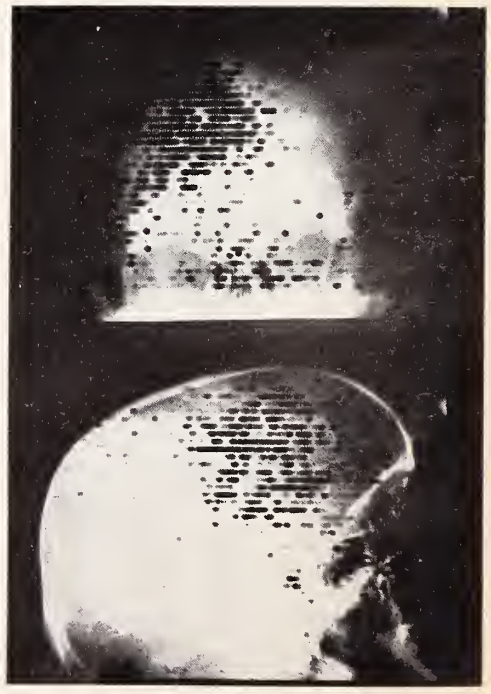

FIGURE 7
GLIOBLASTOMA MULTIFORME: note the high activity, large size, irregular outline and spread across midline through the corpus callosum. The scan provides direct demonstration of the tumor while contrast studies show it only indirectly through displacement of normal structures.

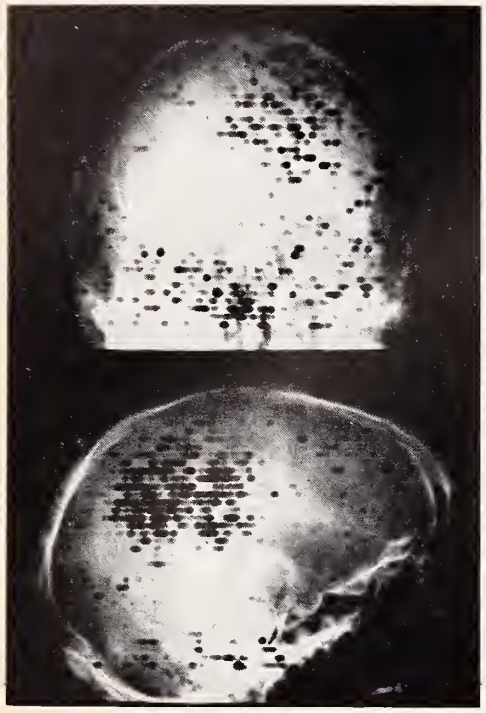

FIGURE 8
METASTATIC NEOPLASM: in general, metastases concentrate the isotope well. They are the most common cause of more than one discrete lesion. This is a metastasis from a bronchogenic carcinoma. Note the location at the junction of the temporal, parietal and occipital lobes.

BRAIN SCAN PERFORMED ON 410 PATIENTS FROM JUNE 1962 THROUGH MARCH 1965

	Positive Scan	Negative or equivocal scan
Glioblastoma Multiforme	18	1
Astrocytoma Grades I & II	8	2
Oligodendroglioma	2	0
Meningioma	8	0
Pontine glioma	0	5
Ependymoma	1	1
Pituitary adenoma	1	1
Metastatic	26	2
Vascular accident less than one month prior to scan	18	13
Subdural hematoma	6	2
Contusion	2	4
Abscess	4	1
Intracerebral hematoma	3	0

Table 1

take in three consecutive lines in two perpendicular projections.

Scanning has proven to be a reliable, simple means of detecting intracranial disease without morbidity. There are many causes of a positive scan other than neoplasm. Although some distinguishing features aid in differential diagnosis, their accuracy remains to be proven. As a screening test the brain scan is unrivaled. As an adjunct to the routine radiographic contrast procedures, it has achieved an important status as a diagnostic aid.

REFERENCES

1. Bakay, L.: *The Blood-Brain Barrier with Special Regard to the Use of Radioactive Isotopes*, Springfield, Ill., Charles C Thomas, 1956.
2. Blau, M., Bender, M.A.: Radiomercury (Hg^{203}) Labeled Neohydrin: New Agent for Brain Tumor Localization. *J. Nuclear Med.* 3:83-93, 1962.
3. Kindt, G. W.: Pattern of Location of Cerebral Metastatic Tumors, *J. Neurosurg.* 21:54-57, 1964.
4. McAffee, J. G., Fueger, G. F.: The Value and Limitations of Scintillation Scanning in the Diagnosis of Intracranial Tumors in *Scintillation Scanning in Clinical Medicine*, ed. by J. L. Quinn, Philadelphia, W. B. Saunders Co., 1964, pp. 183-217.
5. Moore, G. E., Hunter, S.W., Hubbard, T. B.: Clinical and Experimental Studies of Fluorescein Dyes with Special Reference to their Use for Diagnosis of Central Nervous System Tumors, *Ann. of Surg.* 130:637-642, 1949. ◄

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The reliability of a post-exercise electrocardiogram depends on a standardized technic. To be of value, the test should be performed meticulously and all conditions which are subject to variation should be reported.

How Significant Are "Exercise" Electrocardiograms?

MAURICE E. ROUGRAFF, M.D.
Indianapolis*

FOR mortality purposes there are basically only two kinds of chest pain, the pain of cardiovascular disease and non-cardiac pain. It would seem relatively easy with today's modern diagnostic technics to differentiate between these two entities but for a life insurance carrier, it is not always so simple.

Not infrequently a medical director is presented with an application for insurance by an individual with a history of chest pain. Sometimes the review of his diagnostic workup clearly establishes the cause of his symptom. Then the medical director's job is easy. All too often, however, the medical records are inconclusive. A normal physical examination and chest fluoroscopy, for example, does not rule out heart disease; neither does a normal resting electrocardiogram. Though the EKG reassures the reviewer that the changes of myocardial infarction were not present at the time the tracing was performed, it does not rule out coronary insufficiency as a cause of the patient's pain.

The classical description of anginal pain includes the observations that it is brought on by exertion and relieved by rest. This discomfort may be due to the heart's need for more oxygen. Except in severe cases, the heart is adequately supplied at rest but becomes ischemic when enough oxygen cannot be supplied for the exertional effort. Though the heart muscle may continue to labor in an anoxic state for awhile, the strain will be reflected in the electrocardiogram by a shift of the ST segment. This is true, of course, if the EKG is recorded while the heart is under this strain. When the supply of oxygen is equal to the demand, such as in the resting state, the EKG very frequently returns to normal.

It would appear, then, to rule out coronary artery disease, all that is needed is an electrocardiogram taken immediately after exercise. Although some physicians believe this, it is not true! The positive findings of ST depression, etc., will be seen only after sufficient exercise is performed to cause air hunger in the myocardium, and this will vary from person to person. Although most patients will show positive EKG changes immediately after this critical amount of exer-

Proper Procedure

The above features are all incorporated in the exercise electrocardiogram test developed by Dr. Arthur Master. His test calls for a resting EKG, a standardized (for age and weight) amount of exercise calculated to prompt exertion and multiple leads immediately after exercise, at two minutes and six minutes.[1] When properly performed, the Double Master cise, an occasional patient apparently has a time lag, post-exercise, before positive ST changes are noted. In these people, it is also necessary to take tracings at intervals of a few minutes after exercise or the significant changes will be missed. In addition, it is important to remember that though one coronary vessel may be partially occluded, the others may be reasonably normal. Multiple leads post-exercise are absolutely essential to a proper survey of the heart's function. Two-Step Test is a very useful diagnostic tool and frequently requested by medical directors to assist them in evaluating "chest pain" insurance applicants.

Unfortunately, requesting a Double Master Exercise Test and getting one that is properly performed is not always the usual sequence. In a large, national insurance company, all applicants cannot be transported to the home office to have the test performed under controlled conditions. Many of these applicants live hundreds of miles away. It is practical and expeditious for the medical director to request that the test be performed at a local facility which, not infrequently, is not personally known to the examiner. The finished results of these tests can be highly useful in evaluating the insurance risk, but all too often the test or technic is of such poor quality as to be useless.

One of the most frustrating types of so-called exercise tests to evaluate is the test which shows no evidence of exercise effect—a series of tracings showing a resting heart rate with little or no change after exercise. In a well-conditioned athlete this is possible, but in a middle-aged, obese male who rarely exercises, I find such results hard to accept.

Late in 1961, I reviewed every exercise test that we received in our home office medical department. A goal of 500 consecutive tests was set. (This was later modified to exclude females and those applicants under age 30 years because their numbers were too small to be significant). I hoped that the bulk of these would be carefully performed Double Master Two-Step

* From the Medical Department, American United Life Insurance Company, Indianapolis.

Tests because I wanted to tabulate and average the immediate post-exercise acceleration of the heart rate to ascertain if there was any constant that could be reasonably expected in the various age groups. I have long contended that a properly performed Double Master should show a post-exercise pulse rate of at least 100 beats per minute or a post-exercise acceleration of at least 20 beats per minute (except in athletes or well-conditioned, healthy people).

The tests were classified by age group (decades), by results (positive or negative), by amount of post-exercise acceleration of the heart rate and by the style used for testing. If the exercise test consisted of a resting series of EKGs, multiple leads taken immediately post-exercise and approximately two minutes and six minutes thereafter, it was considered "Master in style." Those deviating grossly from this were classified as "others."

Results

Of the 500 exercise EKGs reviewed, 67% seemed to be "Master" in style. Of the "others":

- 2% included no resting tracing
- 3% had no immediate post-exercise EKG
- 3% had the same heart rate before and after exercise
- 3% had a slower rate post-exercise, and
- 22% had no two minute tracing (±1 minute)

Of the 336 exercise tests which were "Master" in style, many were not labeled as to the amount or method of exercise employed. In only 32% did the cardiographer state the specific amount and duration of the exercise. The words "steps, ascents, trips and stairs" are used frequently and presumably synonymously. (Ever since the story of the doctor to whom "40 steps" meant 20 steps up and 20 steps down, I wish everyone would say 40 trips!) In 29% of these tests, the tracings were labeled "Master's" or "Double Master's." In 39% no exercise description was offered. The group referred to as "others," 164 cases, had a similar lack of exercise description—40% of these cases.

This failure to identify the amount and duration of exercise presents a real problem to the reviewing physician. How is he to evaluate this test? Was it a Single Master, A Double Master Two-Step or some home-made variation? Even if the exercise test is performed for the clinician's own records, is not the amount of exercise as necessary to record as the dose of drug prescribed for the patient?

Dr. Master believes the exercise test should be standardized.[2] Yet, in our series, all kinds of exercise variations were described, i.e., jumping on one foot, 50 hops, 20 steps holding ice in hands, etc. One provocative chest pain case was complicated because the applicant was a polio victim confined to a wheel chair. A "Double Master" test was submitted on him with no explanation as to how he was exercised!

When the type, amount and duration of the exercise is not described, the reviewer must evaluate the significance of the test on the evidence at hand. The immediate post-exercise acceleration of the heart rate, PEA, is a good index of the heart's reaction to the test. At least, if the rate increases, you may conclude that something, presumably the exercise, prompted the heart to beat faster. Except in the well-conditioned, healthy person, a properly performed Double Master Two-Step Test should show a noticeable PEA.

In this series of 500 exercise tests, only a handful of applicants were recent athletes. The ages of the applicants ranged from 30 to 69 years with the largest group being those 40 to 49 years of age. Age, except in the youngest group, had little effect on the average PEA (Tables 1 and 2). The PEA for the "Master" style tests was 27 beats per minute. The PEA for the "other" style tests averaged less than 20 beats per minute. The average for all the tests together was a PEA of 22 beats per minute. As would be expected, the standardized Master test gave the more consistent results.

POST-EXERCISE ACCELERATION (PEA) MASTER'S STYLE

Age Group	Beats/minute (average)
30-39	29
40-49	27
50-59	27
60-69	27

TABLE 1

If post-exercise ischemic changes are seen, it is not customary to find them in all 12 leads. It is important, therefore, to take multiple leads after exercise (Master and Rosenfeld have found leads V_4, V_5, V_6, and II most useful!)[1] In the 500 cases reviewed, there was considerable individual variation as to the combination of leads taken. Some took only limb leads, some precordial leads—most cardiographers took a few of each. In five cases, only one post-exercise lead was recorded. In one such case, the test was interpreted as negative but one month after the test the patient suffered an acute myocardial infarction. I shall always wonder if multiple leads taken at the time of his exercise test would not have been of greater diagnostic significance.

The Double Master Two-Step Test is not a trivial exercise. It requires the expenditure of about 8.5 calories per minute, which, except in the well-conditioned person, prompts the heart to greater activity. This expected immediately post-exercise acceleration has been very useful in evaluating the significance of exercise tests especially when the type of test or the amount of exercise is doubtful. It was earlier stated that the average PEA for this

POST-EXERCISE ACCELERATION (PEA) BY STYLES OTHER THAN MASTER

Age Group	Beats/minute (average)
30-39	17
40-49	18
50-59	15
60-69	20

TABLE 2

series of exercise tests was well over 20 beats per minute. (This included those so-called "exercise tests" that demonstrated little or no PEA.) Of those tests that showed a PEA of less than 20 beats per minute, there were 135.

Remembering that these tests were performed in many places and by various technics, some variation in results of exercise was to be expected. But if you accept the theory that a significant PEA is to be expected following a properly performed exercise test, the above number of "slow responders" would seem to cast doubt on the validity of this theory—or some of these "tests" were not adequately performed!

Further investigation into the medical history of these slow responders did reveal additional available information. In approximately ⅓ of this group of "slow responders," our case file showed either prior or subsequent exercise tests. A review of the PEA in these earlier or later tests, in almost all cases, showed a PEA of 20 beats per minute or higher. Of even greater significance, was the number of negative "slow responders" whose tests became positive when the PEA increased to expected limits.

In this series of 500 consecutive exercise EKG tests, 80 showed positive, ischemic changes post-exercise. The average PEA of the positive group was 32 beats per minute. Again, the tests were compared by age of the applicant and the style of the test (Table 3). The "Master" group had 21% positive; the "others" had only 6% of their total number interpreted as positive.

POSITIVE EXERCISE TESTS

Age	Master's Style	Other Styles
30-39	11	4
40-49	23	4
50-59	29	1
60-69	7	1
TOTAL	70	10

TABLE 3

Conclusion

When in doubt as to the amount or type of exercise employed in an EKG test, the immedite post-exercise acceleration (PEA) of the heart rate is a useful indicator of the response to the exercise. In a study of 500 consecutive exercise tests submitted from various sources on male insurance applicants, the Master Two-Step Test consistently averaged about the same PEA regardless of age. The Master exercise test, in comparison to the other styles, also showed significantly more positive results. Any exercise test worth doing should be carefully performed, appropriately labeled, identifying the amount and method of exercise, and should include multiple leads immediately, at two minutes and at six minutes after the exercise. Negative tests showing little or no PEA are of doubtful significance. An exercise test is as significant as the care with which it was prepared and as insignificant as the deviation from the standardized method.

Summary

Medical directors frequently request Double Master Two-Step Tests to assist in the evaluation of insurance applicants with a history of chest pain. A review of 500 consecutive exercise tests shows the lack of uniformity in method of exercise, amount of exercise, style, immediate post-exercise acceleration (PEA) and results. Unidentified exercises present a problem in evaluating the significance of the test. The PEA, however, is a useful index of the response to the exercise. The PEA for the Master Style test averaged by age group is consistent (±27 beats per minute) and higher than the other style tests. More positive results were found in the Master group. For more significant tests, the author pleads for proper testing, identification, multiple leads and standardization of technic.

Acknowledgment

The collection of this data was possible only with the kind co-operation of the A. U. L. selection underwriters, medical personnel and other associate departments. The advice and suggestions of John C. Baker, M.D. and John S. Pearson, M.D. have been most helpful.

REFERENCES

1. Master, A.M., Rosenfeld, I.: Criteria for Clinical Application of the "Two-Step" Exercise Test, *JAMA* 178:283-289, (Oct. 21), 1961.
2. Master, A.M., Rosenfeld, I.: Monitored and Post-Exercise Two-Step Test, *JAMA* 190: 494-500, (Nov. 9), 1964. ◄

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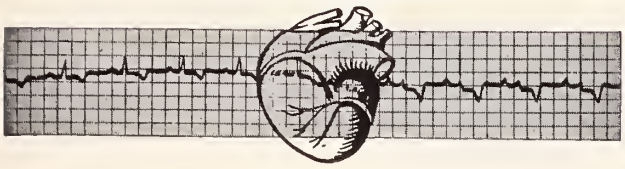
Electrocardiogram of the month



Presented as a regular feature of The JOURNAL, Electrocardiogram of the Month is a series of short talks on cardiovascular diagnosis and treatment, edited by the staff of the Krannert Heart Research Institute, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis.

Nonparoxysmal Nodal Tachycardia (I)

CHARLES FISCH, M.D.
Indianapolis

WITH a few exceptions such as thyrotoxicosis, fever, embolism, anemia, occasionally mitral stenosis, severe heart failure and other less common conditions, a rapid ventricular response in atrial fibrillation indicates the need for further administration of digitalis. Occasionally however, and at times when least expected, "pushing" of digitalis might result in toxic arrhythmias before the ventricular rate is slowed. One such arrhythmia is nonparoxysmal nodal tachycardia. This arrhythmia is recognized by the sudden appearance of an absolutely regular ventricular rate varying usually from 100 to 160 while the basic atrial mechanism, namely atrial fibrillation, remains undisturbed. Continued administration of digitalis may and usually does result in death of the patient.

Figure 1 demonstrates such an arrhythmia. The latter was documented in a 74-year-old man with arteriosclerotic heart disease. Tracing recorded on 3-25-65 demonstrates atrial fibrillation with a ventricular rate of about 160. Following administration of 1.6 mg of digitoxin, the usual response, namely a slowing of the ventricular rate to about 80, was accomplished (3-29-65). On 3-30-65 the patient had a cerebrovascular accident. The ventricular response became perfectly regular at a rate of about 150, indicating the presence of nonparoxysmal nodal tachycardia. The digitalis toxicity was precipitated by the cerebrovascular accident.

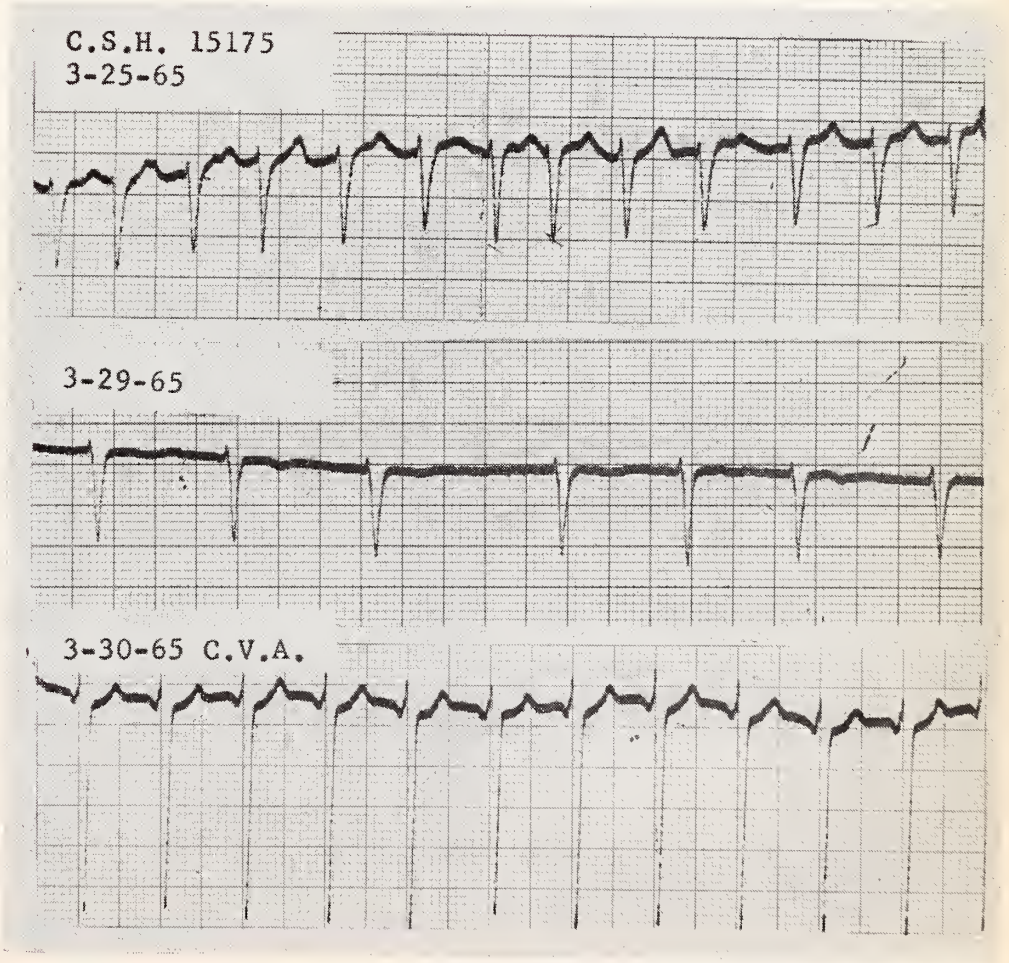


FIGURE 1
THIS figure shows the appearance of nonparoxysmal nodal tachycardia following C.V.A. in a patient with atrial fibrillation.

X-RAY CONFERENCE

Presented as a regular feature of *The Journal*, X-ray Conference is a series of short talks on procedure and radiologic diagnosis, edited by Erich K. Lang, M.D.

Chordoma of the Dorsal and Lower Cervical Canal

ERICH K. LANG, M.D.
*Indianapolis**

A 24-year-old white male was referred for evaluation of intractable pain in his right shoulder. For the past three to four months, the patient had complained of an increasing dull aching pain in the right shoulder which radiated into the triceps muscle area. Various muscle relaxants and other medication had been tried, without pain relief.

Neurologic examination revealed the cranial nerves to be unremarkable. There was no evidence of a Horner syndrome. Sensation was intact in all modalities. The biceps and triceps reflexes were depressed on the right, as compared to the left. Motor examination revealed marked atrophy of the infra-and supraspinatous muscle, as well as the deltoid muscle on the right. Pain was accentuated by extension or flexion of the neck. A clinical impression of a brachial radiculitis was formed, although the exact etiology was not apparent. Roentgenographic studies of the cervical and dorsal spine failed to reveal any abnormalities.

A myelogram (Figure 1) demonstrated an almost complete block at the level of D-3. The myelographic study showed a gradual compression of the right lateral gutter, starting at the level of D-5. The dye column was deviated to the left. The cord demonstrated as a radiolucent defect within the dye column, and was likewise deviated to the left. The right lateral gutter was completely obliterated, however, the dye was able to move cephalid in the left lateral gutter. A space-occupying lesion in the epidural space was suspected and its extension over several segments suggested a lymphoma.

FIGURE 1
NOTE the progressive deviation of the cord shadow to the left side with increasing scalloping of the right gutter. There is no evidence of erosion or rarefaction of the lamina of the vertebrae. An epidural lesion appears to extend in the right gutter from D-6 upward.

Surgical exploration revealed an epidural tumor, extending from C-6 to D-3. The lamina of all cervical as well as dorsal vertebrae appeared to be intact. The tumor was of a ropey consistency, and it was difficult to separate the roots from the tumor, which was finally resected in piece-meal fashion. Histologic sections demonstrated a classical chordoma.

Discussion

Chordomas are tumors frequently found at the level of the neuroporus anterior and posterior, namely the clivus and the sacrum. Usually they become apparent because of marked destruction of bone. Chordomas have been described in the cervical area. However, chordomas in the lower cervical and dorsal area are considered a rarity. Moreover, the presentation of a chordoma as a long stretched epidural tumor is indeed a rarity. As a rule, this type of tumor growth is reserved for lymphomas. ◄

* Radiologist, Methodist Hospital, Indianapolis 46207.

Breast-feeding and the "modern mother"

Despite a mild resurgence of interest in the importance of breast-feeding a few years ago, many women today do not choose to nurse their young. This is for a variety of reasons—social, economic, cultural and sometimes medical. In such cases the physician's task is to find the most suitable means of preventing lactation and easing the pain of breast engorgement.

The means of therapy

The value of hormone therapy for this indication is of course well established. Both androgen and estrogen are known to inhibit the production and secretion of the lactogenic hormone by the anterior pituitary. As estrogen levels decline sharply at parturition, lactogenesis is established. When androgen and estrogen are administered to the patient before the release of the lactogenic hormone lactation and breast engorgement are usually prevented.

The time of therapy

The time of administration of this combined medication is crucial; it must be given early enough to suppress the pituitary prolactin and last long enough to permit physiologic readjustment during the puerperium. Excellent results are most often seen when therapy is administered before the onset of the second stage of labor.

However, factors other than effectiveness must also be considered. The agent selected should not interfere in any way with parturition, subsequent uterine involution and the restoration of normal ovarian cyclic function. Furthermore, it should not cause rebound breast engorgement or other manifestations of hormonal imbalance.

A balanced formulation

Providing single-dose therapy for the prevention of lactation and breast engorgement, Deladumone OB is a potent androgen-estrogen combination with a prolonged action. The optimal balance of androgenic and estrogenic hormones achieved in this preparation minimizes the disadvantages inherent in single hormone therapy, such as rebound breast engorgement. Involution of the uterus and resumption of menstrual cycles are not affected.

As reported in a recent published study (Roser, D. M.: Obstet. & Gynec. *27*:73, 1966), Deladumone OB provided good suppression of breast engorgement in 95.3% and suppression of lactation in 81.1% of 86 obstetrical patients. These results are in general agreement with those of many earlier investigations; in several studies this injectable androgen-estrogen combination proved to be superior to oral medication.

Dosage:

As a single injection of 2 cc. before the onset of the second stage of labor.

Contraindications:

Established or suspected mammary cancer or genital malignancy.

Precautions and Side Effects:

Certain patients may be unusually responsive to either estrogenic or androgenic therapy. In such individuals virilization, uterine bleeding or mastodynia may occur.

Supply:

Deladumone OB, providing 180 mg. testosterone enanthate and 8 mg. estradiol valerate per cc., is available in 2 cc. Unimatic® disposable syringes and in 2 cc. vials. Both preparations are dissolved in sesame oil, with 2% benzyl alcohol as a preservative. *Before use, consult product literature for full prescribing information.*

Deladumone® OB

Squibb Testosterone Enanthate (180 mg./cc.) and Estradiol Valerate (8 mg./cc.)

Single-dose injection for lactation inhibition

SQUIBB *'The Priceless Ingredient' of every product is the honor and integrity of its maker.*

ASTHMA:

IMMUNOLOGICAL AND NON-IMMUNOLOGICAL

One of a series of case reports illustrating the differential diagnosis in patients with symptoms of asthma.

IRVIN CAPLIN, M.D.
JOHN T. HAYNES, M.D.
Indianapolis

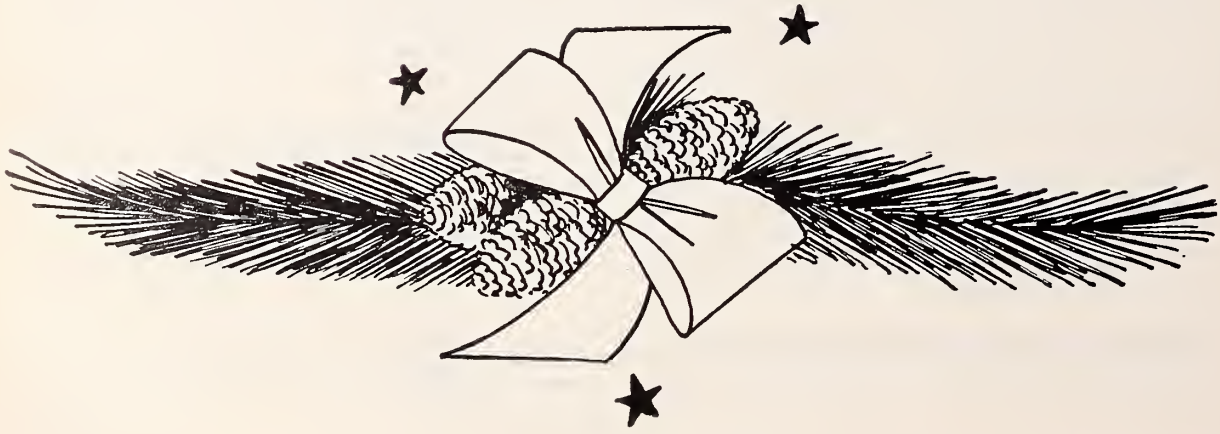
A 62-year-old physician was seen because of asthma which he had had for 20 years. His asthma had become progressively more severe during the preceding three weeks so that he was bothered night and day. In the past he had had mild episodes which were relieved by Amesec. He gave a history of having had a myocardial infarction 20 years before. Physical examination revealed some increase in the A-P diameter of the chest. Blood pressure was 140/90. Crepitant rales were heard in both lung bases and there was a 1+ pedal edema.

A timed vital capacity revealed a first second capacity of 0.5 liters and a total capacity of 1.5 liters. Chest x-ray (Figure 1) revealed marked pulmonary fibrosis and congestion of both lung fields with blunting of the right costophrenic angle. There was also a question of fluid in the right costophrenic angle and interlobar fissure on the right. The heart was slightly enlarged; a cardiogram revealed a peri-infarction block. He was treated with bed rest and Thiomerin and lost nine pounds overnight with a marked improvement in his dyspnea.

FIGURE 1
PULMONARY fibrosis with congestion of both lung fields, fluid in the right costophrenic angle and right interlobar fissure. There is also cardiac enlargement.

This patient represents both pulmonary emphysema and asthma, along with myocardial disease with left and right sided heart failure. A heart which is normal in size or slightly larger than normal on x-ray examination in a patient with emphysema is frequently indicative of heart disease or heart failure. The typical heart in pulmonary emphysema resembles a small, hanging drop. ◄

1815 N. Capitol Ave.
Indianapolis 46202



Frankly, most antihypertensives are pretty good if you give an adequate dose. I'm looking for one with a simple regimen so that mix-ups in doses and therefore the chance of side effects are minimized.

Regroton®

chlorthalidone 50 mg. reserpine 0.25 mg.

1 tablet daily brings pressure down

Advantage: Both components of Regroton are long-acting.
Average dosage: One tablet daily with breakfast.
Contraindications: History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases.
Warning: Discontinue 2 weeks before general anesthesia, 1 week before electroshock therapy, and if depression or peptic ulcer occurs. With administration of enteric-coated potassium supplements, the possibility of small bowel lesions should be kept in mind.
Precautions: Reduce dosage of concomitant antihypertensive agents by one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take particular care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use with caution in patients with ulcerative colitis, gallstones, or bronchial asthma.
Side effects: Nausea, vomiting, diarrhea, muscle cramps, headaches and dizziness. Potential side effects include angina pectoris, anxiety, depression, drowsiness, hyperglycemia, hyperuricemia, lassitude, leukopenia, nasal stuffiness, nightmare, purpura, urticaria, and weakness.
For full details, see the complete prescribing information.
Availability: Bottles of 100 and 1000 tablets.

Geigy

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of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

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Pension Tax Equality Needed

SENATOR HARTKE, with cosponsors Smathers of Florida and Morton of Kentucky, introduced a tax amendment in October to liberalize the deductions on the pension plan for self-employed persons. When the original legislation was passed in 1962, it was estimated that about six million self-employed would establish retirement plans and that nine million of their employees would be benefited also. In the four years of the plan's operation, fewer than 40,000 of the possible 15 million persons have been signed up.

It is interesting to note that, in spite of the fact that the plan has always been referred to officially as applying to the self-employed, heretofore its opponents have referred to it as the plan for doctors and lawyers; now the plan's boosters attribute its benefits to small businessmen and farmers.

The proposed amendment would allow deduction of the full amount of the taxpayers contribution to his pension plan, instead of one-half as written in 1962. It would also remove the 30% limitation on "earned income" to be considered for plan purposes.

The plan was under discussion for many years prior to its enactment in 1962. Its purpose was and is to provide the self-employed with the same pension plan and tax deduction benefits that have been accorded the employees of corporations for a long time. It has always been promoted as an "equalizer" in this regard. No special treatment has ever been sought by the self-employed in lobbying for the legislation, although special favors and the desire therefore have been insinuated by the law's opponents.

The fact that the 15,000,000 possible beneficiaries have been able to or have chosen to take advantage of the original legislation in the ratio of approximately one out of four hundred would seem to indicate that it was deficient as originally drawn. Senator Hartke's amendment is a step in the right direction.

Pharmaceutical Advertising

MODERN pharmaceutical advertisements present an array of important knowledge which allows them to function as a preview, and an early preview at that, of the pharmacopeia, insofar as new drugs are concerned. The advertising pages of your state journal may be depended upon to outline the indications, contraindications, side effects and other vital information for the new and potent introductions to drug therapy.

Michigan Medicine, the Journal of the Michigan State Medical Society, in its September issue, highlights this function of a state medical journal so well in editorial comment, we are reproducing their words in toto. Their title is "Advertisements Worth Reading."

"It is virtually impossible to keep up with reports on all of the new drugs and other technical as well as nontechnical products available to the physician. No doctor has the time to expose himself to all the available journals that contain this information. The type of advertisement that appears in *Michigan Medicine* helps to keep our readers abreast of the new products.

"Many of us have become irritated by the banal material we see on television such as the anvil in the headache or the mechanical stomach with the faucet dripping acid. Perhaps this has resulted in a very generalized anatagonism against any and all kinds of advertising. This is unfortunate. The type of advertising found in this

journal we believe to be worthwhile or it would not be accepted.

"The revenue that comes from our advertisers is not only appreciated but also makes possible the publication of *Michigan Medicine* at a reasonable cost to each member of M.S.M.S. But of very great importance and value is the basic information that can be found in the pages they provide."

Pharmaceutical advertisements have two functions—one to promote the sale of drugs, the other to provide financial "muscle" for medical journals. Both are important functions. Publication of this journal is made possible, in part, by advertising revenue. We firmly believe and trust that promotional value is realized by the advertisers in return for their contribution. However, if advertising revenue was not necessary, state medical journals would consider the educational value of drug advertising as essential in their editorial policy. It is the only convenient source of the latest information on newly introduced drug products.

Emergency Room Emergency

The latest emergency is the emergency room itself.

"Ways must be found to ease the rising pressures on hospital emergency services if emergency medical care is to be improved in the United States," says the AMA in a press release.

Emergency rooms in general are in trouble because they have too many customers, because they are understaffed, and, according to the AMA handbook "Emergency Department—A Handbook for the Medical Staff," because they have not had the aggressive planning, the up-to-date refurbishing and the up-to-the-minute improvements which are characteristic of the other hospital departments.

The AMA is conducting a campaign to improve emergency medical services all over the country and is publishing the "Handbook" as a means of promulgating the information which has been gathered and compiled for this purpose.

The increase in emergency room patients and the tendency for patients to "drop-in" with non-emergency conditions has increased gradually over the last decade or more. The increase has been gradual but it has not been small—statistics show that emergency visits increased by 16 million or by 175% from 1954 to 1964.

Whether this is due to the fact that doctors' offices are not open at night as much as they once were, whether increased urbanization affects patient behavior, whether the obvious fact that the hospital is usually much better equipped for such services than is the doctor's office influences patients, or whether everyone is just naturally becoming more oriented to hospital care, is not of importance in the solution of the problem.

Facts are facts—and when a patient, sick or not, emergency or not, presents himself or herself in a hospital, all legal, humanitarian and medical rules dictate that medical service should be made available. The hospital is responsible and must discharge its responsibility in some way.

The medical profession also has a large part of the responsibility, and must arrange to discharge its responsibility, and on a private practice basis, if at all possible.

Close to half of emergency room patients are not considered by medical attendants to be true emergencies. This fact, too, is not of much importance, because it is the estimate of the patient which must rule the situation, and sometimes, what appears to be a trivial, non-existent, minor or inconsequential illness proves later to be major and life-threatening.

When the AMA Handbook is published, every hospital that is likely to be involved in the emergency problem, and every member of the medical staff of such hospitals, should study the book. Probably if ingenuity comparable to that which is commonplace in open-heart or large vessel surgery is brought to bear on the emergency room problem, most of the worries will be over.

Guest Editorial

The Fifty-Year Club*

E. S. JONES, M.D.
Hammond

YOUTHFUL AUDIENCES such as this usually are not apt to get very excited at the prospect of having a speaker reminisce about something that happened 50 years ago. Frankly, joining a "Fifty-Year Club" is not my idea of something to keep me awake too many nights. However, *this* "Fifty-Year Club" is not an ordinary run-of-the-mill club — it is the Class of 1916! Now, I want to assure you that I am not the least bit biased and prejudiced in this matter but you just can't argue with facts.

The 1916 class was undoubtedly the greatest group ever graduated from Indiana University — not only the medical school, but the entire class. Stop and think of all the men who have been in high office, such as Justice Sherman Minton, Paul McNutt, and from the medical standpoint, General Paul Hawley and Admiral William Wilcuts. I always think of the Class of 1916 in terms of each of the members being like a stone cast in a pool of water with the ripples spreading wonderful benefits widely, not only throughout Indiana, but throughout the entire nation.

I don't want to get lost in too many reminiscences, but I think you might be interested in recalling a few of them. I remember quite vividly Ed Kime who became professor of anatomy. I remember that when *his* professor would dispute one of Ed's answers, Ed would refer the old professor to the specific page and line and read it. And Ed was always right!

The medical class of 1916 was noted for having literally closed the amphitheater of the old medical building at Senate and Market Streets. One morning one of our more illustrious members who was sitting at the top of the

* Response made at the induction of the 1966 class of the Fifty-Year Club at the annual banquet, French Lick, October 12, 1966.

amphitheater, which was almost straight up, started a package of ammonia valerinate down the aisle. By the time it hit bottom, most everyone had left the lecture room. Since the culprit did such a good job in getting rid of that old dilapidated lecture room, I will not mention any names.

The Class of 1916 succeeded also in making Dr. Dean Emerson miserable for a number of years, and the good Dean's only moment of happiness came when we graduated and left. I don't know why he should have felt that way, but admittedly we did seem to involve poor Uncle Charlie in more than his share of hot water.

I don't want you to think that it was all fun, and all that we did was "horse around," since there was a lot of serious work and study. In fact, the ax was quite sharp at Indiana University those years. A lot of weeding was done along the journey, and of the almost 300 who entered the premedical course, only 33 hard workers graduated.

That accomplishment reminds me of a story that one of the members who is located in a town near Indianapolis tells about one of his patients: A four-year-old was asked by her mother in October what she would like for Christmas. The girl replied she would like a baby brother. Since it was then October, Mother explained that it might be a little too late to have a baby brother for a Christmas present. The little girl reminded her mother that daddy was a building contractor and said, "Mommy, why don't you do like Daddy does?" When Mommy asked her what she meant, the girl replied — "Put more men to work." I doubt that even the Class of "16" could have helped much in this situation.

You may have guessed that I look back with fond memories on the Class of 1916, and I know you will excuse my pride in thinking it to be one of the greatest things that ever happened to Indiana University. I would like to paraphrase General MacArthur in saying that "The memories of the Class of 1916 may gradually fade, but they shall never die."

Editorial Notes...

Seventh-Day Adventists abhor smoking and apparently, at least in California, enjoy a spectacularly low death rate from malignancy and other respiratory diseases as a result thereof. A report in the October 10 issue of *JAMA* states that out of 11,071 Adventist males observed between 1958 and 1962, 850 died, but only 28 deaths were due to lung cancer or emphysema. About 12% of all male deaths in California are due to respiratory diseases. The only differences evident between the Adventists and the average Californians were that the former were slightly older, had higher incomes and had had much less exposure to tobacco. The clincher is that, of the 28 deaths, only one man was a long-term Adventist; the other 27 were mostly recent converts and all had a long history of smoking.

An Anti-Coronary Club in New York with 814 members on a "prudent" low-saturated-fat-diet for ten years is reported to have demonstrated less obesity, less hypertension and only one-third as many "coronary events" as did a control group of 463 men in the same age group and with the same smoking habits. Author Dr. George Christakis and others from the New York City Department of Health are cautious in drawing conclusions but suggest that serum cholesterol determinations might be useful in clinical practice. Refer to the November 7 issue of *JAMA*.

Less than half of the public have ever had a physical examination that included tests for cancer, but over 90% said they would if asked to do so by their doctor. This is the result of a public opinion research done for the American Cancer Society, which concludes that most people think that doctors are for treatment, but not for conducting checkups. The remedy suggested for this situation is to urge doctors to urge their patients to have regular checkups.

Dr. Charles A. Hufnagel, at one time in surgical practice in Richmond, Indiana, and since 1950 professor of surgery at Georgetown University, Washington, D. C., announced recently the introduction of the fourth of a series of artificial heart valves which he has been instrumental in developing. The newest valve is known as a "unit tri-leaflet valve." It was made possible by the development of new plastics and the ability to incorporate an anti-clotting chemical in the material which lines the valve. The three other valves — the ball-in-chamber, the dacron leaflet valve, and the caged-discoid valve — have contributed to extended life expectancy and health of hundreds of patients, but are being rendered obsolete by new developments, such as the "unit tri-leaflet valve." ◀

MOLECULAR REMODELING—

laboratory exercise or clinical necessity?

More than twenty-five years have passed since the discovery of the diuretic activity of sulfanilamide started pharmacologists on a succession of molecular remodelings to find the ideal diuretic.

Diuresis—a sought-after clinical effect from an unwanted side effect

It started in 1937 when a clinician reported that the administration of a sulfonamide was sometimes accompanied by an unexplainable side effect—metabolic acidosis.[1] Three years later the side effect was explained. The sulfonamide radical of sulfanilamide inhibited carbonic anhydrase,[2] the enzyme responsible for converting carbon dioxide and water to hydrogen ions and bicarbonate ions.

Later, other investigators showed by dog experiments that metabolic acidosis probably resulted when the inhibition of carbonic anhydrase upset the exchange of hydrogen and sodium ions, causing increased excretion of sodium as the bicarbonate.[3]

It was twelve long years after the first report of the unexplainable side effect (metabolic acidosis) that it was finally shown that large doses of sulfanilamide administered to edematous patients were indeed capable of promoting diuresis.[4] However, the possibility of toxic effects from its prolonged use and its relatively weak diuretic action made it impractical for clinical use as a diuretic.[5]

Because the inhibition of carbonic anhydrase seemed to be the key to effective diuresis, investigators began to look for more potent enzyme inhibitors —in the hopes that they would be more effective diuretics.

The most important of these early compounds, acetazolamide, enjoyed several years of fairly wide clinical use.

Its carbonic anhydrase inhibitory activity was several hundred times greater than that of sulfanilamide.[6] The increase in inhibitory activity, however, increased not only the excretion of sodium and bicarbonate ions, but also the excretion of potassium.[7] And, like its predecessor, acetazolamide precipitated mild acidosis. Its prolonged use could result in hypokalemic acidosis.[7]

The 'thiazides'—an answer to the metabolic acidosis caused by carbonic anhydrase inhibition

Despite the fact that the sulfonamide group appeared to be responsible for carbonic anhydrase inhibition which in turn appeared to be responsible for diuresis, investigators began to synthesize compounds with structural alterations to the sulfonamide group.

The first major breakthrough came with the synthesis of chlorothiazide. Altering the sulfonamide group did indeed alter the ability of chlorothiazide to inhibit carbonic anhydrase—it was only 1/10th as potent as acetazolamide in inhibiting the enzyme.[8] Despite the drop in inhibitory potency, however, chlorothiazide proved to be an effective diuretic—an observation that led to the conclusion that its diuretic action was due to some mechanism other than its action on carbonic anhydrase.[9,10]

For effective diuresis, chlorothiazide was administered in daily dosages ranging from 250 to 2000 mg.[11] It increased the excretion of sodium and chloride; and, to a lesser extent, potassium and bicarbonate.[11] The excretion of potassium appeared to be maximal at higher dose levels at which, theoretically, the carbonic anhydrase inhibitory effect is more active.[11] Its prolonged use, therefore, could sometimes result in metabolic hypokalemic, hypochloremic alkalosis.[7]

Naturetin—effective diuresis with more favorable electrolyte balance

Other thiazides followed—with improvements being aimed at two particular areas: 1. attempts to increase diuretic action in relation to the milligram potency of the drug, and 2. attempts at a more favorable sodium/potassium ratio in the urine, i.e., to decrease the excretion of potassium while maintaining the excretion of sodium.[12]

One of these, Naturetin, Squibb Bendroflumethiazide, has made advances on both these points. "By adding a 3-benzyl radical to hydroflumethiazide a rather dramatic reduction in dose range is accomplished. With this drug, effective sodium excretion is obtained with doses between 2.5 and 10 mg., which is a 200 to 1 ratio as compared to chlorothiazide..."[13]

Moreover, due probably to its virtual lack of carbonic anhydrase inhibition, Naturetin (bendroflumethiazide) has been shown to cause less potassium and bicarbonate loss and less alteration in urinary pH than either chlorothiazide or hydrochlorothiazide.

Naturetin is outstandingly effective not only in establishing, but also in maintaining, excretion of retained fluid in edematous patients. And its duration of action is sufficiently prolonged to allow a single daily administration in most patients. Naturetin is also an effective antihypertensive agent.

Contraindications: Severe renal impairment; previous hypersensitivity.

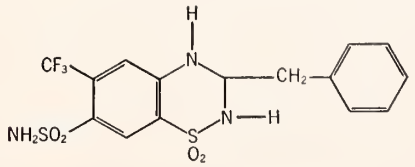
Warning: Ulcerative small bowel lesions have occurred with potassium-containing thiazide preparations or with enteric-coated potassium salts supplementally. Stop medication if abdominal pain, distension, nausea, vomiting, or G.I. bleeding occur.

Precautions: The dosage of ganglionic blocking agents, veratrum, or hydralazine when used concomitantly must be reduced by at least 50% to avoid orthostatic hypotension. Electrolyte disturbances are possible in cirrhotic or digitalized patients.

Side Effects: Bendroflumethiazide may cause increases in serum uric acid, unmask diabetes, increase glycemia and glycosuria in diabetic patients and may cause hypochloremic alkalosis, hypokalemia; cramps, pruritus, paresthesias, and rashes may occur.

Supplied: Naturetin (Squibb Bendroflumethiazide) 5 mg. and 2.5 mg. tablets. Also available Naturetin c̄ K [Squibb Bendroflumethiazide (5 or 2.5 mg.) with Potassium Chloride (500 mg.)]. For full information, see Product Brief.

References: **1.** Southworth, H.: Proc. Soc. Exper. Biol. & Med. *36*:58, 1937. **2.** Mann, T. and Keilin, D.: Nature *146*:164, 1940. **3.** Pitts, R. F., and Alexander, R. S.: Am. J. Physiol. *144*:239, 1945. **4.** Schwartz, W. B.: New England J. Med. *240*:173, 1949. **5.** Friedberg, C. K., in Moyer, J. H., and Fuchs, M.: Edema Mechanisms and Management, Philadelphia, W. B. Saunders Co., 1960, p. 259. **6.** Cumming, J. R.; Tabachnick, E., and Seelig, M., in Moyer, J. H., and Fuchs, M.: op. cit., p. 254. **7.** Werko, L., in Moyer, J. H., and Fuchs, M.: op. cit., p. 188. **8.** Beyer, K. H., Jr., in Moyer, J. H., and Fuchs, M.: op. cit., p. 274. **9.** Maren, T. H., and Wiley, C. E.: J. Pharmacol. & Exper. Therap. *143*:230, 1964. **10.** Earley, L. E., and Orloff, J.: Ann. Rev. Med. *15*:149, 1964. **11.** Fuchs, M., and Mallin, S. R., in Moyer, J. H., and Fuchs, M.: op. cit., p. 276. **12.** Ford, R. V., in Moyer, J. H., and Fuchs, M.: op. cit., p. 290. **13.** cited in Fuchs, M., and Mallin, S. R. (ref. 11): op. cit., p. 283.



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to reduce excess fluid
or high blood pressure

President's Page

Dear Doctor:

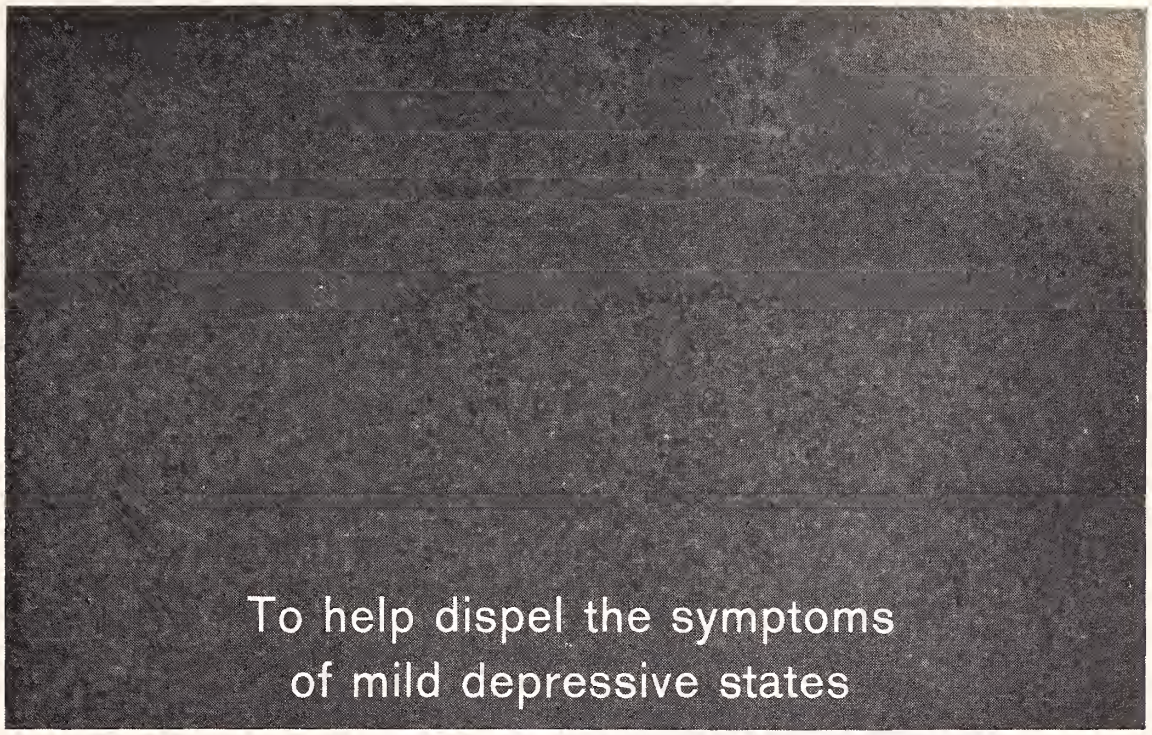
"Merry Christmas and a Happy New Year" very often sounds hollow during this time of the year but it is a necessary salutation for the joyous Holiday Season.

I would hope that physicians in Indiana might stop and take a serious look at improvement of patient care in Indiana. I would hope that we might try to improve our service to the people of Indiana through better understanding and better contributions of time and effort to the work of county, district and state societies.

May you, your family and your patients have a most joyous Holiday Season regardless of your faith. In the coming year, may the God of your forefathers cause His light to shine upon you in the coming year and give you peace and strength in the knowledge that you have given the cure of disease, the prevention of disease, and peace and strength to that most all important person, your patient.

Merry Christmas and a Happy New Year.

Eugene S. Kiefer M.D.



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Formulas: Each 'Dexamyl' Spansule® capsule (brand of sustained release capsule) No. 1 contains 10 mg. of Dexedrine® (brand of dextroamphetamine sulfate) and 1 gr. of amobarbital, derivative of barbituric acid [Warning, may be habit forming]. Each 'Dexamyl' *Spansule* capsule No. 2 contains 15 mg. of Dexedrine (brand of dextroamphetamine sulfate) and 1½ gr. of amobarbital [Warning, may be habit forming].

The following is a brief precautionary statement. Before prescribing, the physician should be familiar with the complete prescribing information in SK&F literature or *PDR*.

Precautions: Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Do not use in patients taking MAO inhibitors. Excessive use of the amphetamines by unstable individuals may result in a psychological dependence; in these instances, withdraw the medication. Use cautiously in pregnant patients, especially in the first trimester. *Side effects:* Insomnia, excitability and increased motor activity are infrequent and ordinarily mild.

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The Woman's Auxiliary

REPORTS TO ISMA

May I take this opportunity to thank your officers and members of the House of Delegates for the honor, courtesy and very excellent attention afforded me while reporting to them at your recent meeting at French Lick? The more than 2,800 members of your auxiliary work hard to produce such an annual report and are repaid and encouraged when it is received so enthusiastically. We are now past the halfway point in our present year's efforts. We trust that the report given next October will be even more gratifying.

At this happy season, we pause for a brief time to take stock of ourselves and our concern for others. May I, through these words of an unknown author, extend to each of you, our husbands and friends, the auxiliary's most sincere greetings?

"Christmas is your faith in all that is good in the world — Christmas is the selfless spirit of doing for others — Christmas is laughter and friendship — and the spreading of cheer — And it is the guileless wonder of childhood — Christmas is the sweet joy of families united — It is the tender knowledge that you're loved by someone — And that you have someone to love — Christmas is believing in prayer — and the Power that answers it — Plus the right to sing of your belief in the way of your choice — Christmas is all the things free men fight for — Let us keep it shining for all the world."

Mazo D. Scales

Annual Meeting Dates of Professional Medical and Allied Organizations

AMERICAN MEDICAL ASSOCIATION ANNUAL CONVENTION
Date June 18-22, 1967
Place Atlantic City, Ga.

NORTHERN INDIANA PSYCHIATRIC SOCIETY
Date Fourth Wednesday of every month, September through June
Place For location and program, inquire Beatty Memorial Hospital, Westville

INDIANA NEUROPSYCHIATRIC ASSOCIATION
Date Second Wednesday of the month, October through May, excluding December
Place The Athenaeum, Indianapolis

AMERICAN COLLEGE OF SURGEONS, INDIANA CHAPTER
Date April 7-8, 1967
Place Morris Inn, Notre Dame University, South Bend

INDIANA ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY
Date May 12-14, 1967
Place Stouffer Inn, Indianapolis

INDIANA PHARMACEUTICAL ASSOCIATION
Date July 18-20, 1967
Place French Lick Sheraton Hotel, French Lick

INDIANA ACADEMY OF GENERAL PRACTICE
Date May 3-4, 1967
Place Murat Temple, Indianapolis

INDIANA STATE MEDICAL ASSOCIATION CONVENTION
Date October 9-12, 1967
Place Indianapolis

INDIANA PUBLIC HEALTH ASSOCIATION
Date April 26-27, 1967
Place Indianapolis

INDIANA STATE ASSOCIATION OF MEDICAL ASSISTANTS
Date April 28-30, 1967
Place Van Orman-Roberts Hotel, Muncie

INDIANA ROENTGEN SOCIETY
Date May 7, 1967
Place Indianapolis

Plan to Attend

January 22-23, 1967
Palmer House
Chicago, Illinois

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Indiana University School of Medicine Library Teletype Service

The Indiana University School of Medicine Library has installed a teletype facility to improve the reference and loan services to the patrons in the state. This service is designed to aid those patrons outside of Marion County who have not had direct access to the library. Through the cooperation of the Indiana State Library, this terminal will be an open line to state library teletype installations in public libraries in 22 Indiana cities. Over 100 other communities are tied into the network via telephone. There is no charge for the teletype or phone call. The school of medicine library will endeavor to have material for specifically requested titles in the mail within 24 hours after receipt of the request. If the library does not have the material, the patron will be notified within the same period.

Instead of the inconvenience of writing a letter or making a long distance phone call to the school of medicine library, patrons in these cities can contact, by phone or in person, their local public library. Their requests, either for specific references or for a bibliography, will be transmitted to the school of medicine library. *The patron must tell the public library making the request that the material is to be supplied by the school of medicine library or the request will be channeled through the Indiana State Library and then to the school of medicine library.*

In the case of serials articles, photocopies are usually supplied. However, if the serial is in poor condition and/or cannot be photocopied or if the material is a book, the original is sent. Photocopies become the property of the patron. There will be no charge for the first 20 exposures of any one request. There will be a $.10 charge for each additional exposure. There will be no charge for the teletype call. When original material is sent to a patron, he will pay only the return mailing charges. The due date for original materials will be indicated, and the patron is expected to have the material returned to the library by the date due. The loan period is 30 days with no renewals.

Requests for bibliographies should include the following information:

a. detailed statement of the subject of interest including the specific phases of the subject (i.e., diagnosis, etiology, pathology, therapy)
b. statement regarding date span to be covered
c. languages to be included

Requests for specific materials should include the following information:

a. serials: author(s), title of article, title of serial, volume, inclusive pagination of the article, and date
b. books: author(s), title of book, edition, place of publication, publisher, and date

An additional advantage of this service is that approximately ten other medical libraries in the United States, as well as the National Library of Medicine and the Library of Congress. have teletype facilities. If materials are not available at the school of medicine library, these libraries will be contacted. The same loan regulations apply to materials borrowed through interlibrary loan.

CITIES WHOSE PUBLIC LIBRARIES HAVE TWX INSTALLATIONS:

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Fort Wayne (Allen County Library)
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Kokomo
Lafayette (Wells Memorial Library)
Lake County (Lake County Library, Griffith, Indiana)
Lowell
Madison (Jefferson County Library)
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Seymour (Jackson County Library)
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CITIES OUTSIDE OF MARION COUNTY WHOSE PUBLIC LIBRARIES ARE AUTHORIZED TO MAKE REQUESTS VIA TELEPHONE TO THEIR DESIGNATED TWX MEMBER LIBRARY:

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Danville
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Edinburg (Wright-Hageman Library)
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Gleaned from the British Medical Journal

JACK W. HICKMAN, M.D.
Indianapolis

More Data on Lumbar Sympathectomy Benefits

The second part of a study of lumbar sympathectomy is reported by Myers and Irvine in which they evaluated this procedure as a benefit for skin ischemia.[1] Lumbar sympathectomies were performed on 35 patients. Twenty-one of these patients had suffered with rest pain, and thirteen of them were benefited by the procedure. Rest blood flow and peak blood flow were increased in 27 of the 35 patients as measured by plethysmography done before and after the surgical procedure. This procedure seems to be of definite benefit to the majority of patients, but the authors were troubled with the inability to predict which patients would respond poorly to the procedure. They are not alone in this.

"Recurrent Cystitis" is Probably a New Primary Infection

Using a rather elaborate method of E. Coli typing, McGeachie studied 49 patients with urinary tract infections over a period of four years.[2] The purpose of the study was to determine whether repeated infections of the urinary tract were largely recrudescences of inadequately treated primary infections, or if they were, in fact, a fresh, new reinfection. The author's conclusion was that the majority of cases were due to reinfection rather than a recrudescence. Also of interest was the fact that most of the new reinfections occurred within six months of the initial attack. He regards this as possible evidence that the previously infected tissue is in a state that makes it more susceptible to infection.

The Next Great Specialty Will Deal With Drug Reactions

A paper entitled "Ill-health Due to Drugs" is beautifully written and illustrates the hazards of some of our potent therapeutic agents.[3] In this paper, Dr. Wilson cites the dangers of errors in dosage, delayed excretion or metabolism, interaction of drugs, undesirable side-effects, secondary effects, toxic reactions, hypersensitivity reactions and psychological factors. He points out that the same agent in different colored tablets may have a different incidence of side-effects and draws attention to the positive placebo effect. No new or startling facts are presented in the paper, but his plea for common sense and caution in the prescription of drugs is important and timely.

Clinical Laboratory Fails to Differentiate Pneumonia & Embolism

A rather small study, but a disturbing one, is reported by Schonell et al.[4] This group studied 10 patients with clinical pneumonia and another 10 patients with the clinical and radiologic diagnosis of pulmonary infarction. They obtained SGOT, LDH, bilirubin, alkaline phosphatase, and thymol turbidity determinations serially in all 20 patients throughout their illnesses. The disturbing result is that they were unable to differentiate between pneumonia and pulmonary infarction on the basis of the test results. For example, only three of the 10 patients with pulmonary infarction had elevated LDH's, and none of these had an elevated serum bilirubin. Furthermore, four of the 10 patients with pneumonia had elevated LDH's. Further larger studies are needed to either confirm or dispute this study.

BIBLIOGRAPHY

1. Myers, K. A., Irvine, W. T.: An Objective Study of Lumbar Sympathectomy — II. Skin Ischaemia, *Brit. Med. J.* 5493:943-947.

2. McGeachie, James: Recurrent Infection of the Urinary Tract: Reinfection or Recrudescence. *Brit. Med. J.* 5493:952-954.

3. Wilson, G. M.: Ill-health Due to Drugs, *Brit. Med. J.* 5495:1065-1068.

4. Schonell, M. E., Crompton, G. K., Forshall, J. M., Whitby, L. G.: Failure to Differentiate Pulmonary Infarction from Pneumonia by Biochemical Tests, *Brit. Med. J.* 5496:1146-1148. ◄

Now, now, Mrs. Forsythe, we've never lost a cold patient yet.

When she's experiencing acute discomfort from cold symptoms, it's small wonder the patient becomes distressed about her condition.

She will breathe easier when you prescribe Novahistine LP. Novahistine LP is a long-acting decongestant that helps restore normal mucus secretion and ciliary activity—physiologic mechanisms which prevent infection of the respiratory tract. A dose of two tablets taken in the morning and repeated in the evening will usually keep air passages clear for 24 hours.

Use cautiously in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention.

Caution patients who operate machinery or motor vehicles that drowsiness may result.

Each Novahistine LP tablet contains: phenylephrine hydrochloride, 25 mg., and chlorpheniramine maleate, 4 mg.

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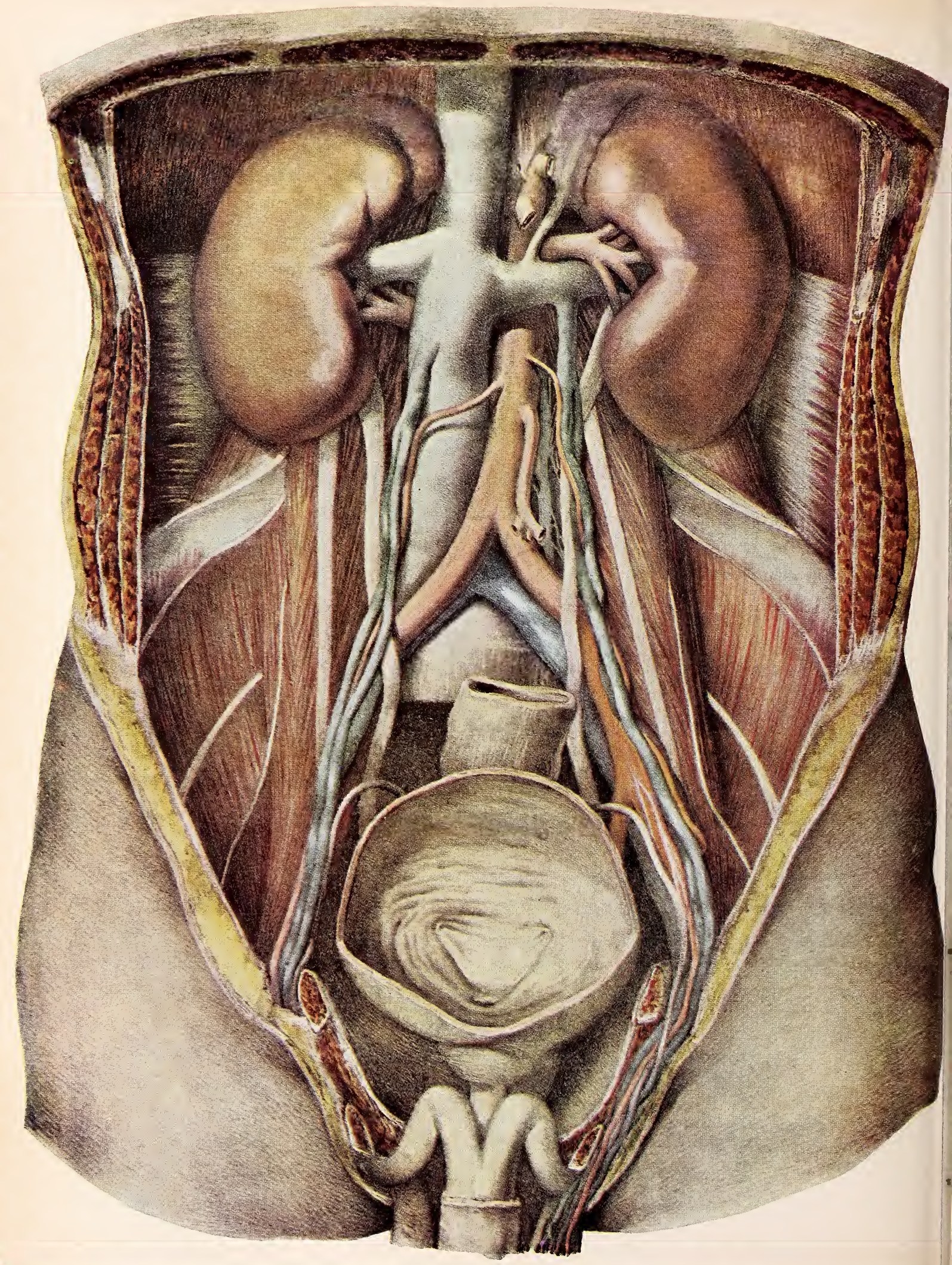
For relief of nasal congestion.



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Normally produces high and persistent levels in blood and high concentrations in bile and urine.

Significant inherent stability.

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Indications: Urinary tract infections, especially those caused by *E. coli*, *Proteus mirabilis*, and *Streptococcus faecalis* and *viridans;* respiratory infections caused by *H. influenzae*, pneumococci, streptococci, and nonpenicillinase-producing staphylococci; and gastrointestinal infections caused by *Shigella* and *Salmonella*, including *Sal. typhosa.*

Contraindications: Hypersensitivity to penicillin; infections due to penicillinase-producing staphylococci and other penicillinase-producing bacteria.

Precautions: If allergic reaction occurs, discontinue ampicillin and administer epinephrine, corticosteroids, antihistamines and/or pressor amines as indicated. Transient moderate elevation of SGOT values of undetermined significance was noted in a few infants. Liver and kidney function as well as hematopoietic tests are advisable during therapy, particularly in infants. As with other antibiotics, precautions should be taken against gastrointestinal superinfection. Safety for use in pregnancy has not been established.

Adverse Reactions: Occasional mild side effects as urticaria, skin rash, pruritus, diarrhea, nausea and vomiting. There have been no reports of blood dyscrasias, liver or kidney damage. Anaphylaxis has been reported.

Composition: Capsules, 250 mg.

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ISMA Supports Eradication Of "Disease Ridden" City Dumps

THE Indiana State Medical Association has gone on record in support of the eradication of open dumps throughout the state.

In a resolution voted upon at the final meeting of the House of Delegates at French Lick, Indiana, October 13, the association advocated that disposal of community waste products in open dumps be discontinued and supplanted by sanitary land fills.

The association endorsed the State Health Department's similar position regarding such dumps and gave authorization to its Commission on Legislation to cooperate in promoting enactment of necessary legislation during the forthcoming General Assembly.

Dr. Eugene S. Rifner, Van Buren, who assumed the office of president of the association during the convention said:

"The ISMA has long endeavored to do everything possible to improve the health of the citizens of Indiana. In keeping with this policy, we have decided that one of the major objectives of our legislative committee this year will be the eradication of these disease ridden dumps. Rats, vermin and insects of all kind are carriers of many diseases from the filth of these dumps to the sanctity of our homes. The eradication of these dumps will be a great step forward in our fight to improve everyone's health."

DR. EUGENE S. RIFNER, (left) Van Buren, president of the Indiana State Medical Association, inspects the open dump at French Lick, Indiana during the 117th Annual Convention of the Association there. With him are A. C. Offutt, M.D., Commissioner of Health in Indiana and Dwight W. Schuster, M.D., Indianapolis, chairman of the association's Commission on Legislation. The association will pursue a program of urging the state legislature to enact a law to eliminate open dumps.

a Private Psychiatric Center at Jacksonville, Illinois, *since 1901*

Complete psychiatric treatment in an environment for cure. A 40 bed hospital with the most modern diagnostic and therapeutic equipment for the treatment of nervous and mental disorders.

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Defective drivers outnumber defective autos by almost fifty-to-one. Several drivers were found at autopsy to be so drunk they couldn't walk, hence had to drive. Corrective measures are outlined.

Traffic Deaths in Lake County

WEI-PING LOH, M.D.
ALEXANDER S. WILLIAMS, M.D.

Gary*

TRAFFIC deaths are a subject of great concern to the medical profession and the general public as well. Motor vehicle accidents in this country caused nearly 50,000 deaths in 1965. The all-time number of deaths, as far as recorded, passed the 1,000,000 mark nearly six years ago. If the current automobile accident rate continues, one of every two Americans can look forward to being injured by a car. Until something can be done to reverse the upward trend, motor vehicle accidents will continue to be the leading cause of death for our young citizens in their most productive period of life.

Indiana recorded a total of 1,511 traffic deaths in 1965. Among the 92 counties, Lake County scored the highest figure, 155 deaths according to the state record, or 164 deaths according to our record. Lake County is the second most populous county in Indiana and is located in its northwest corner adjacent to Chicago. The county is well known for its heavy industry and has a population approaching 600,000. The year-round heavy traffic in the county may partly explain its high traffic tolls.

The purpose of this article is to analyze in detail the 164 traffic deaths. Possible remedies for reduction of the injuries will be discussed. We believe our study is one of the few pioneer studies on traffic deaths and offers the first scientific report on this subject ever published in Indiana.

Analysis of Accidents

Type: There were 139 motor vehicle accidents in which 164 persons were killed. The 139 accidents included eight car-train accidents which killed 13 persons, three car-motorcycle accidents which killed three persons and five car-bicycle accidents which killed five persons. The remaining 123 accidents involved automobiles and a few trucks and buses. Pure train accidents are not included.

The 139 fatal accidents included 70 single-car accidents, 52 two-car accidents and 17 accidents involving three cars or more. One of the accidents in-

* From the Lake County Coroner's Office and the Department of Pathology, Methodist Hospital of Gary, Inc., Gary.

Dr. Loh is the chief pathologist for the Lake County Coroner's Office and the Gary Methodist Hospital and associate professor of pathology at the Chicago Medical School.

Dr. Williams is the Lake County Coroner.

TIME AND DAY OF THE WEEK OF FATAL ACCIDENTS

Time	Days of the Week							Total Number of Accidents
	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.	
Midnight—4:00 A.M.	3	6	1	3	2	8	7	30
4:00 A.M.—8:00 A.M.	1	2	3	1	3	6	4	20
8:00 A.M.—Noon	—	—	—	2	2	1	3	8
Noon—4:00 P.M.	4	5	2	1	6	3	3	24
4:00 P.M.—8:00 P.M.	5	9	2	1	6	3	5	31
8:00 P.M.—Midnight	4	1	3	3	5	7	3	26
TOTALS	17	23	11	11	24	28	25	139

TABLE 1

volved the maximum of five cars in which only one person was killed.

Time: There were more accidents and deaths during each of the months of March and April than in any other months of the year. Table 1 gives the time and day of the week when the fatal accidents occurred.

Of the 139 accidents, more occurred during late afternoon, evening and night hours than during the hours between 8:00 A.M. and noon. There were more accidents on Friday, Saturday or Sunday than on Wednesday or Thursday. On this basis, the safest time to drive was between 8:00 A.M. and noon on Wednesday or Thursday.

Cause: "Speeding" was the leading cause of accident (Table 2). This is followed by "loss of control of car" and "unsafe passing." A high percentage in the category of "loss of control of car" was related to alcohol intoxication. It is significant to point out that "defective automobile," particularly defective brakes, was responsible for only three accidents.

Analysis of Victims

Type of Fatality. Out of the 164 fatalities, 81 were drivers, 57 were passengers and 26 were pedestrians. There were 121 single fatalities in 121 accidents (Table 3). Others were multiple fatalities, meaning two or more persons killed in each of the 43 multiple fatality accidents. In one of the accidents involving two cars, there were five persons killed.

Age and Sex. Within the group of 81 drivers, only seven were females; 74 were males. Most of the drivers killed were below 50 years of age, and many of them were between 20 and 40 years. A detailed analysis is presented in Table 4.

Alcohol Intoxication. Only 41 of 81 drivers killed had blood alcohol studies. Forty of them showed evidence of drinking and only one of them was negative for blood alcohol. It is important to point out that roughly 75% of

CAUSE OF FATAL ACCIDENT

Cause	Number of Accidents	Percentage
Speeding	52	37
Loss of control of car	32	23
Unsafe passing	16	12
Rushing into traffic	13	9
Disobeying signal	4	3
Improper turn	3	2
Defective automobile	3	2
Following too close	1	1
Cause unknown	15	11
TOTAL	139	100%

TABLE 2

TYPE OF FATALITY

Type of Fatality and Number		Killed	
		Number	Percentage
Single fatality	121	121	74
Double fatality	14	28	17
Triple fatality	2	6	4
Quadruple fatality	1	4	2
Quintuple fatality	1	5	3
TOTALS	139	164	100%

TABLE 3

AGE AND SEX OF THE 164 VICTIMS

Age	Drivers		Passengers and Pedestrians	
	Male	Female	Male	Female
20 and under	8	—	20	15
21 - 30 years	21	1	4	4
31 - 40 years	15	3	4	4
41 - 50 years	18	—	6	3
51 - 60 years	5	1	3	3
61 - 70 years	6	2	9	3
71 and above	1	—	4	1
Subtotal	74	7	50	33
TOTAL	81		83	

TABLE 4

BLOOD ALCOHOL OF THE DRIVERS KILLED

Percentage by Weight		
—0.05	—0.17	—0.13
—0.03	—0.17	—0.17
—0.16	—0.22	—0.19
—0.25	—0.25	—0.18
—0.16	—0.35	—0.20
—0.07	—0.24	—0.26
—0.22	—0.22	—0.14
—0.11	—0.12	—0.17
—0.18	—0.22	—0.25
—0.18	—Negative	—0.22
—0.18	—0.24	—0.12
—0.15	—0.09	—0.16
—0.16	—0.02	—0.15
—0.24	—0.11	

TABLE 5

MAJOR CAUSE OF DEATH

Major Cause	Number of Victims	Percentage
Head injury (skull fracture, brain damage, etc.)	80	48
Thoracic injury (fracture, internal hemorrhage, etc.)	43	26
Abdominal injury (rupture of internal organs and massive hemorrhages, etc.)	16	10
Multiple injuries, or a combination of above	13	9
Neck injury (fracture, damage of spinal cord, etc.)	7	4
Extensive burns	5	3
TOTALS	164	100%

TABLE 6

those drivers killed and tested showed significant intoxication with a blood alcohol level of 0.15% and above. One of the drivers had a blood alcohol level as high as 0.35%. Table 5 gives the actual blood alcohol levels of the 41 drivers tested.

Major Cause of Death. Necropsies were performed on 60% of the victims. Other victims showed evident cause of death and did not require necropsies. Most of the victims died of head or thoracic injuries (Table 6).

Preventive Measures

The drivers or passengers in automobiles were fatally injured in one or more of the following five patterns:

A. Death due to ejection. In this case the victim was ejected through the door opening, windshield, open convertible or even side window, and sustained fatal head injuries and sometimes thoracic and abdominal injuries (Figures 1, 2, 3, 4). The preventive measures for the injuries in this category include a) constant and proper use of seat belts and b) safety door latches and hinges. The use of seat belts was considered by Huelke and Gikas[1,2] as the most effective measure for the prevention of this type of injury.

B. Death due to steering assembly impacts. In this category the damage often came from the steering wheel, the end of the steering column and the gear shift lever. This type of injury is increasing in incidence, while injury due to ejection is decreasing. We all realize that more and more cars are now equipped with seat belts for prevention of ejection death but impact against the steering assembly is still a big problem. The 1967 automobiles are improved in that direction. We still don't know whether this is going to solve the problem. In this category, the driver often received thoracic and abdominal injuries be-

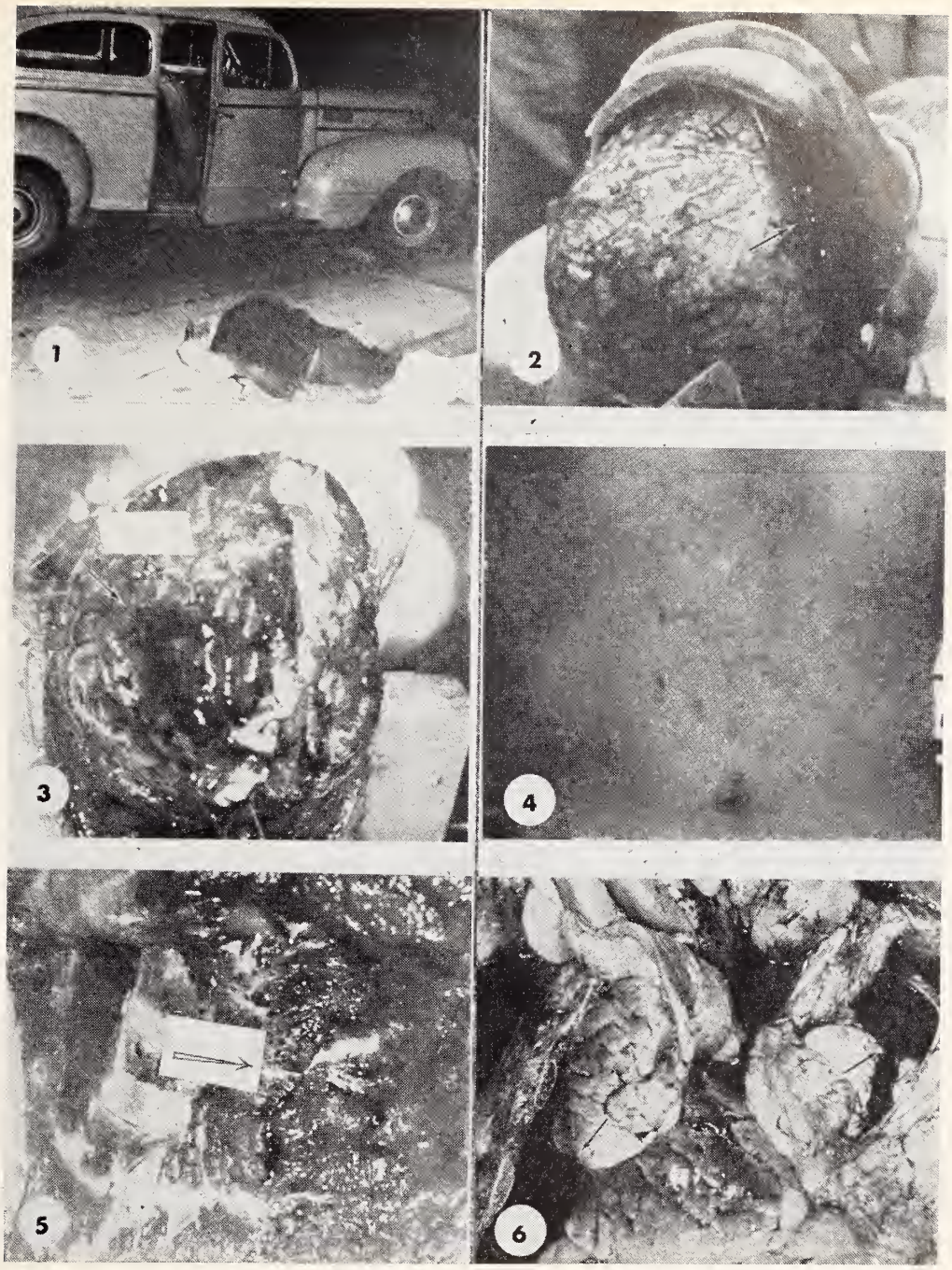

Figure 1. Scene of ejection death. The victim (foreground) was a front seat passenger.

Figure 2. Fatal epidural and subdural hemorrhage (arrow) due to ejection injury.

Figure 3. Fatal subarachnoid hemorrhage (arrow) due to ejection injury.

Figure 4. Ejection injury with tire marks on abdomen.

Figure 5. Fractures of ribs and sternum (arrow) due to impact against steering assembly.

Figure 6. Fatal hemothorax (arrows) due to impact against steering assembly.

cause of impacts against the steering assembly (Figures 5, 6, 7, 8). Preventive measures should include a) collapsible steering wheel and steering column, b) possible use of shoulder belts to reduce forward movement and c) modified gear shifting system to reduce possible injuries from impacts against those structures.

C. Death due to instrument panel impact. Damage in this instance came from forward movement of the head against the instrument panel or displacement of the instrument panel toward the occupant. Here we commonly saw head injury due to direct impact (Figures 9, 10) and sometimes abdominal injury (Figures 11, 12, 13). The preventive measures should include a) energy-absorbing or well

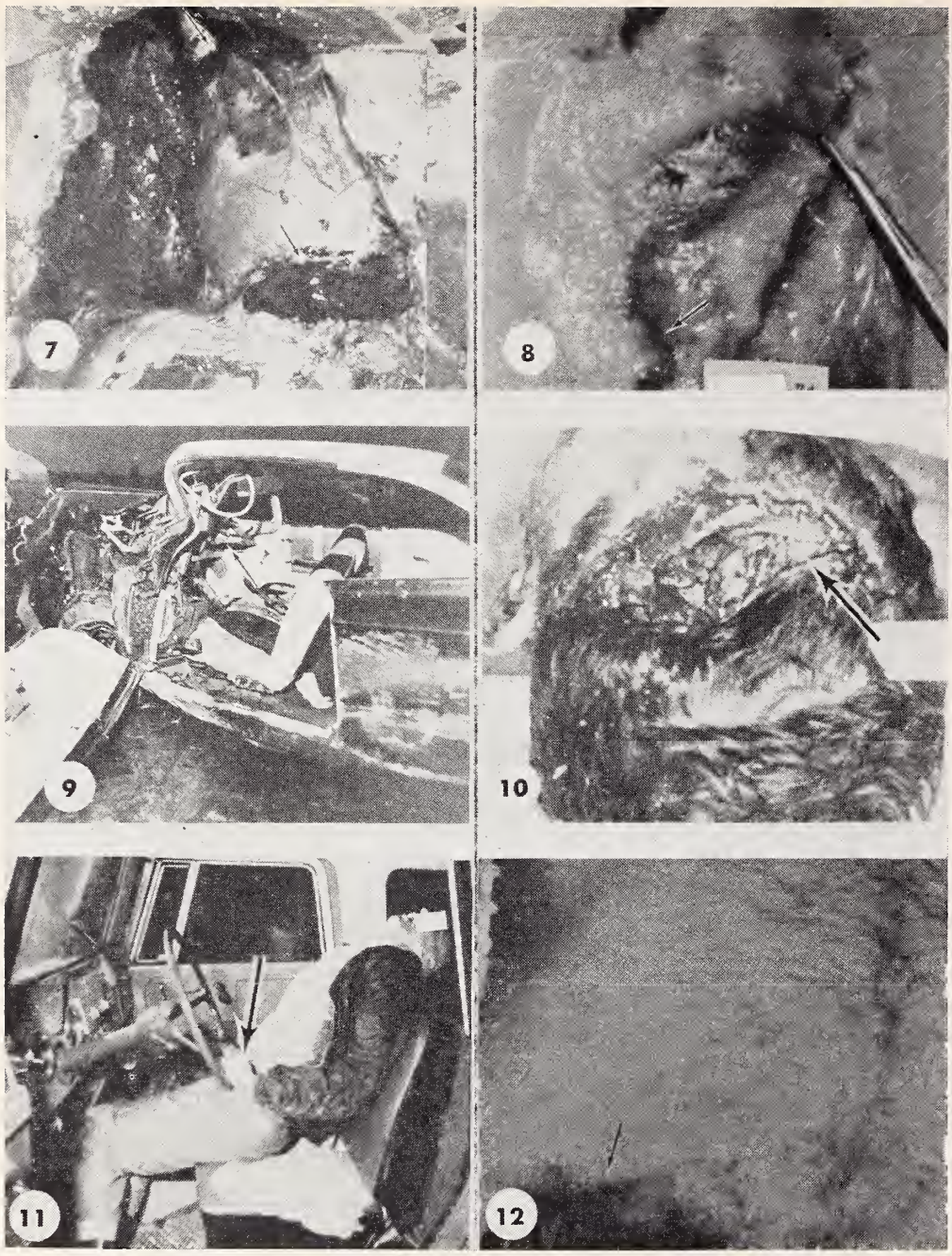

Figure 7. Rupture of aorta with hemopericardium (arrows) due to impact against steering assembly.

Figure 8. Rupture of heart (arrow) due to impact against steering assembly.

Figure 9. Damaged automobile showing deformed instrument panel (arrow).

Figure 10. Fatal skull fracture and lacerations of brain (arrow) due to impact against instrument panel.

Figure 11. Scene of accident showing impact of abdomen against steering wheel (arrow).

Figure 12. Large area of ecchymoses on abdominal wall (arrow) due to impact against steering wheel.

padded instrument panel, b) smoothly contoured instrument panel knobs and c) possible use of shoulder belts and helmets. The use of helmets is somewhat theoretical because of the inconvenience involved.

D. Death due to door impacts. In this circumstance, the side door collapsed inward and the passenger's compartment collapsed because of a side impact (Figures 14, 15, 16). This type of injury often gives damage to the head, neck or any part of the body. Preventive measures include a) strong side door, b) possible use of seat belts and shoulder belts to prevent free movement or tossing of the body inside the automobile.

E. Death due to collapse of roof and supporting structures of the automobile. In this case the heavy weight from the roof and supporting structures reached the head and the neck first, resulting in fractures of the head and neck (Figures 17, 18). Here the preventive measures should include a)

stronger roof and supporting structures, b) possible restraints to prevent undesirable movement of the occupants inside the automobile and c) well padded sun visors, safety mirrors or any other structures which may hit from above.

Summary

1. This paper presents a detailed study of the 139 fatal motor vehicle accidents which killed 164 persons in Lake County, Indiana during 1965.

2. The type of accidents, time and cause are analyzed. Speeding, loss of control and unsafe passing were found to be the three leading causes of accidents. Defective automobiles were responsible in only three accidents.

3. Of the 164 deaths, 81 were drivers, 57 passengers and 26 pedestrians.

4. The type of fatality, age and sex incidence are analyzed.

5. Roughly 75% of the drivers killed were intoxicated with blood alcohol level at or above 0.15%.

6. The mode of injury, a case illustration and preventive measures are discussed.

7. Seat belts alone are not the final answer. Other safety features are needed to prevent or to reduce the injuries or fatalities. Above all, the driving habits, skill, avoidance of the use of alcohol and drugs, better highways, tougher requisites for obtaining a license by the driver, better traffic signals — all these are needed in order to promote traffic safety.

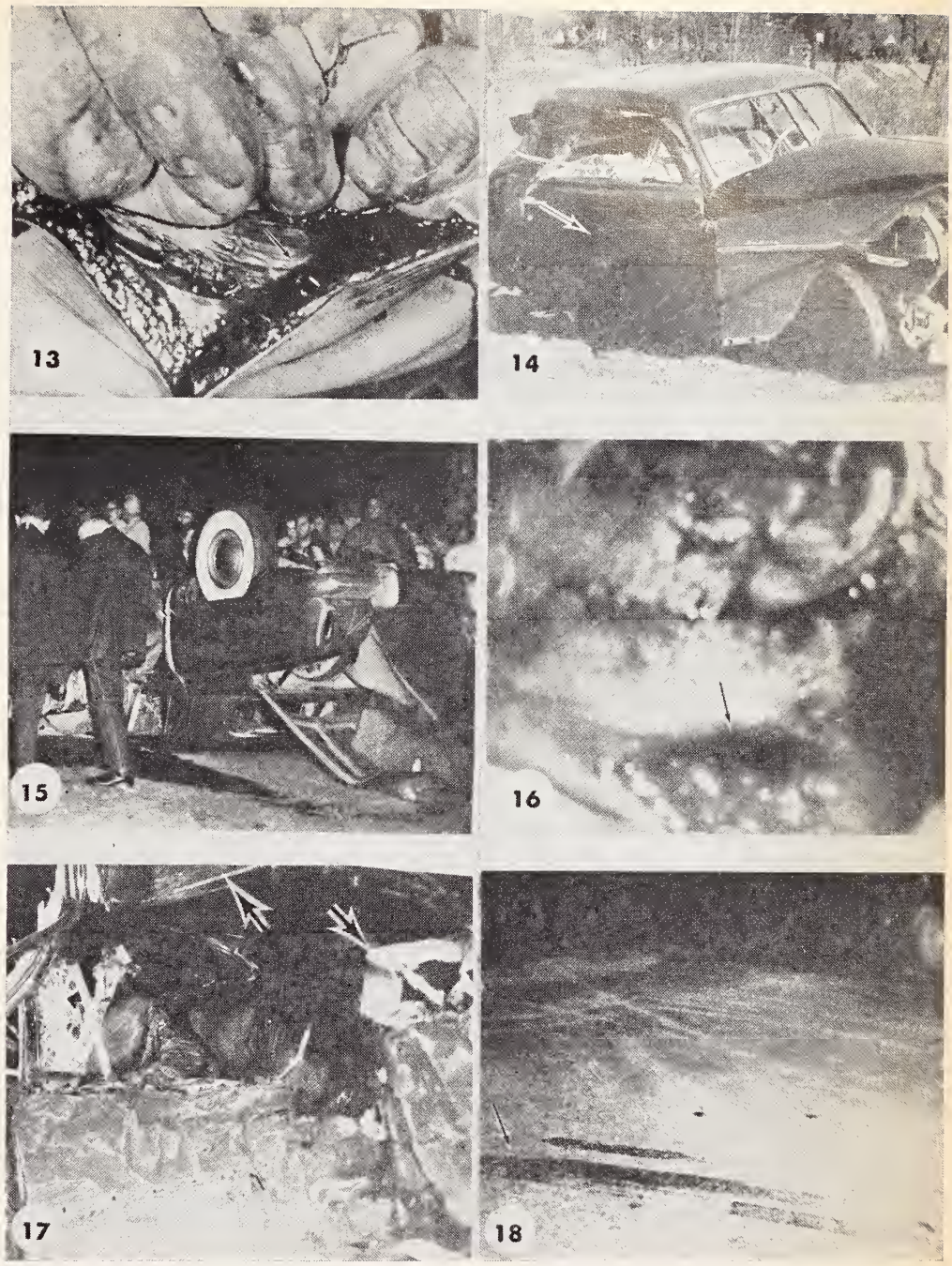

Figure 13. Fatal hemoperitoneum (arrow) due to rupture of internal organs following impact against steering wheel.

Figure 14. Damaged automobile showing evidence of door impact (arrow).

Figure 15. Scene of accident showing overturned automobile following a side door impact.

Figure 16. Large laceration of neck (arrow) as result of side door impact.

Figure 17. Damaged automobile showing collapse of roof and supporting structures (arrows) and two victims inside.

Figure 18. Skidding marks (arrow) on ground indicating high speed traveling and loss of control.

Acknowledgment

The authors are grateful to Mrs. Elizabeth Thornton and Mrs. Ann Carr for their secretarial help.

REFERENCES

1. Huelke, D. F., Gikas, P. W., Hendrix, R. C.: *Patterns of Injury in Automobile Accidents: A Review of 231 Autopsy Cases*, Proceedings, Sixth Stapp Conference, University of Minnesota, Nov., 1962, pp. 3-11.
2. Huelke, D. F., Gikas, P. W.: Causes of Death in Automobile Accidents — Can Seat Belts Really Save Lives? *J. Mich. State Medical Society*, 63:351-354, 1964.

Blue Shield and Physicians

(One of a series prepared by Blue Shield)

Indiana Blue Shield was created by the medical profession. Direction is administered through the Blue Shield Board of Directors and four committees: Executive, Physician Relations, Liaison-ISMA and Finance.

The Blue Shield Board of Directors includes 23 members. Thirteen are active practicing physicians representing each medical district in the state. These physicians are elected at their various ISMA district meetings. Six are physicians representing various medical specialties which are nominated by the Council of ISMA. It is the intent of the Council in nominating these members to see that all specialties are represented. Four are lay members representing industry, labor and finance. All are elected to serve three-year terms, and at the last meeting of the House of Delegates of the ISMA, a resolution was passed that the tenure of physicians on the board be limited to three successive terms of three years each.

Each year the Blue Shield Board of Directors elects four officers: president, vice-president, secretary and treasurer. The elected president appoints all members of the Physician Relations Committee and Finance Committee. Four members of the Liaison-ISMA Committee are appointed by the president of Blue Shield, and three are appointed by the ISMA president. The Blue Shield Board of Directors hires an executive vice-president who is responsible to the board for the administration of the corporation. The board also elects the members of the executive Committee.

One of the primary reasons for the widespread acceptance of Blue Shield by the American people is the fact that Blue Shield is guided by physicians. Blue Shield is the most impressive evidence medicine has ever given that it is capable of helping people pay for medical service.

At the PR Institute in Chicago held last August, F. J. L. Blasingame, M.D., executive vice-president of the American Medical Association, said: "Medicine is not practiced in an economic vacuum. The physician has an obligation to avoid waste of financial resources, always behaving in the prudent economic interest of the patient, commensurate with adequate, quality care. We need to give increasing attention to voluntary health insurance and prepayment and promote them vigorously. Properly used, these methods of financing, already widely accepted, can be of even greater service in financing health care. They remain one of our principal bulwarks against the complete federalization of health care financing for persons under 65."

In looking ahead to the possible implementation of Title XIX by the various states, Charles L. Hudson, M.D., president of the AMA, said on October 10, 1966, in Chicago: "Just as the AMA recommended that you take active part in the administration of Title XVIII, so now will we recommend that you act as carriers for Title XIX if and when they are authorized."

Norman A. Welch, M.D., former president of the American Medical Association, made these comments in a similar vein. "Blue Shield holds in the palm of its hand the survival of professional freedom in this country. Doctors who participate in Blue Shield do more to preserve the private practice of medicine than by any other single effort." ◄

W. C. Huddlestone
Communications Division

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Since shoes are the foundation for the entire body they deserve scientific fitting as to the person's size, last and foot shape.

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This scientific shoe fitting and corrective application is a service offered by Heidenreich and Son who operate the **Heid's Health Shoe Store** at **411 N. Illinois St., Indianapolis, Indiana.**

Your referrals and prescriptions will receive accurate, conscientious attention at reasonable, ethical charges. No job too big, none too small.

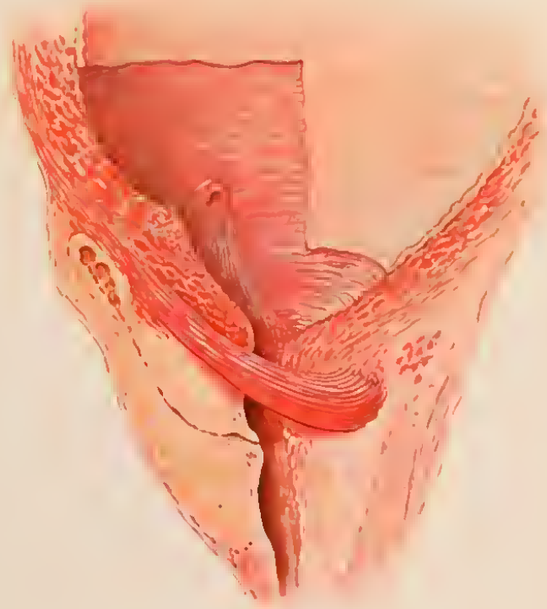
LIFT

GENITOURINARY TRACT SPASM

Spastic conditions of the genitourinary tract as a result of inflammation or calculi are often difficult to treat due to the combination of voluntary and involuntary neural control of the system. Urine enters the bladder in periodic spurts brought about by successive peristaltic waves that begin in the smooth muscle of the renal pelvis and pass downward. The normal anatomical constrictions of the ureters are of clinical importance because they frequently inhibit the passage of small calculi.

Abnormal distention of the bladder as a result of an obstructed outlet due to stricture of the urethra or an adenomatous prostate often requires consideration of the smooth muscle involved. Because prostatic tubules invade the internal smooth muscle layer of the urethra, unusual enlargement of the prostate impedes the sphincter-like action of this muscle. Micturition, with inflammation of the bladder and attending atonicity, is more frequent and in cases of long duration (e.g. tuberculosis) contracture of the bladder approaches a permanent state. The clinical importance of the smooth musculature in the urinary tract cannot be overemphasized.

SMOOTH MUSCULATURE OF THE URINARY TRACT



Artist's rendering of the urinary bladder illustrating the trigone, circular, and longitudinal layers of smooth muscle. Note the spray of fibers which passes from the trigone to the wall of the urethra.

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Philips Roxane Laboratories
Medical Illustration Series
Number Five — SPACOLIN
Additional copies available on request.

The ureters are composed of three layers of smooth muscle, an inner longitudinal layer, a middle circular layer, and an outer longitudinal layer which course the entire length from the renal pelvis to the wall of the bladder where the ureters open as slit-like apertures for the most part retaining their own musculature. They are fairly uniform in size except for three slightly constricted portions, one at the ureteropelvic junction, the second at the pelvic brim, and the third at the extreme lower end of the ureter as it passes through the bladder wall.

The smooth musculature of the bladder is constituted in three general layers with poorly defined boundaries. The outer layer is composed mainly of longitudinal fibers which extend to the neck of the bladder where certain bundles unite to form a loop around the anterior surface of the vesical orifice. Within this loop, the circular layer forms a wedge below the outlet and flows down the urethra in an oblique direction surrounding the canal as a thin layer which, when stimulated, provides an upward pull on the urethral canal. The upward pull of this loop combined with the downward pull of the longitudinal layer gives a sphincter-like action to the musculature at the bladder neck although no true sphincter is present. The musculature of the trigone arises from the longitudinal muscle fibers of each ureter and spreads over the muscles of the bladder wall.

The male urethra is for the most part mucous memhrane which contains loosely arranged longitudinal and circular smooth muscle layers. In the prostatic part at the neck of the bladder, the circular layer is highly developed and acts in harmony with the descending array of circular fibers of the bladder contributing to the sphincter-like control of the neck.

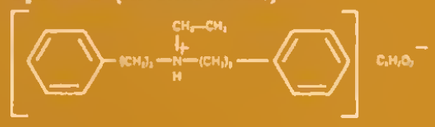
Spacolin (Alverine citrate) is a musculotropic antispasmodic which acts directly on the smooth muscle of the genitourinary tract with rapid onset and long duration. Because the parasympathetic nervous system is avoided, anticholinergic side effects do not occur. Moreover, Spacolin, (Alverine citrate) is ideally suited for relief of smooth muscle spasm in the presence of prostatic hypertrophy.

smooth muscle spasm

GENITOURINARY TRACT SPASM

PHARMACODYNAMICS OF SPACOLIN®
(Alverine citrate)

Spacolin (Alverine citrate)



- A potent musculotropic counter-spasmodic.
- Little or no effect on normal muscle tonicity and motility.
- Spasmolytic effect is 2½ to 3 times stronger than papaverine.
- Unrelated to atropine or atropine-like drugs.
- Therefore no atropine-like side effects such as dry mouth, blurred vision, constipation and urinary retention.
- Not contraindicated in glaucoma or prostatic hypertrophy.

FAST RELIEF OF SMOOTH MUSCLE SPASM

SPACOLIN®
(Alverine citrate)

Each tablet contains: Alverine citrate.....120 mg.

INDICATIONS: Smooth muscle spasmolytic for use in spastic colon, spastic conditions of the gastrointestinal tract, biliary dyskinesia, cholecystitis, spasm associated with peptic ulcer,* achalasia, pylorospasm, spasm attendant to diarrhea, spastic conditions of the genitourinary tract attributable to inflammation and calculi, certain primary dysmenorrheas and as an aid in cystoscopic, esophagoscopic and gastroscopic examinations.

PRECAUTION: Caution is recommended when using in hypotensive patients.

SIDE EFFECTS: In common with other smooth muscle depressants, Spacolin temporarily lowers blood pressure.

DOSAGE: One tablet after meals 1 to 3 times daily at discretion of physician. When treating spasm associated with peptic ulcer, achalasia or pylorospasm, administer tablets ½ hour before meals. In dysmenorrhea, one tablet 3 times daily starting at onset of discomfort.

SUPPLIED: Bottles of 100 and 500 - 120 mg. tablets.

*Antacid and dietary measures are of primary importance in ulcer treatment and should not be neglected

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Medicine At Law

DECISIONS AND OPINIONS

Highlights of recent court actions pertaining to health and medicine from *The Citation* prepared by the Law Division of AMA.

State Medical Society's Property Tax-Exempt—The property of a state medical society, containing the society's executive offices, meeting rooms, and a medical library, was used exclusively in work for the moral and mental improvement of the public. The property was, therefore, tax-exempt, the New Jersey Supreme Court ruled.

The society is supported by the dues of its members, reasonable charges to offset the costs of review courses made available to physicians and dentists, and the holding of meetings underwritten by various groups interested in the field of medicine. No rental fee is paid by the paramedical organizations and other groups interested in the medical field for their use of the society's meeting rooms. No profit is intended from any part of the society's activities, and there was no evidence that there was any profit even from those functions for which an admission charge was made. The society's work contributes to the general health and welfare of the community. The society does not compete with private enterprise and does not primarily aid one segment of private enterprise.

Not all meetings and programs conducted by the society are attended by the general public, but this is due solely to the limited interest of the public in the particular meeting or program. The society makes the educational benefits which it offers available to the public to the maximum degree possible. The library is open to anyone who wishes to use it.

The property would not be tax-exempt, if the society engaged in any activities in the fields of legislation, protecting its members and their professions, or of medical economics. The record established that the society engaged in no activities in those fields.

The restriction of society membership to physicians and dentists and the charging of the membership fee were not grounds for denying the tax ex-

TREASURY DEPARTMENT
BUREAU OF NARCOTICS
WASHINGTON, D.C. 20226

GENERAL CIRCULAR NO. 266

TO ALL REGISTRANTS:

During the twelve month period ending December 31, 1965, there were 2,503 thefts of narcotic drugs from all classes of persons registered under the Federal narcotic law. This is the largest number of thefts ever reported in a single year, and the thefts accounted for a loss of 132.86 kilograms (292.90 pounds) of narcotic drugs.

Although most registrants provide adequate safeguards for their narcotic stocks, some registrants do not, and the increase in thefts leads us to again issue a warning that continued vigilance must be exercised and secure places of storage provided for narcotic stocks. The addicts, as well as the narcotic peddler may resort to diversion of legitimate stocks as the supply of illicit drugs becomes restricted.

Section 151.471 of Regulations No. 5 requires that "Narcotic drugs and preparations shall at all times be properly safeguarded and securely kept . . . ." In every case, appropriate security measures must be taken depending on the kind and size of stock, the immediate surroundings and the general circumstances. Manufacturers and wholesale dealers especially, who constitute the source of supply for other registrants and who are generally known to carry substantial supplies, should be alert to see that their stocks are fully protected. A recent theft from a wholesale dealer resulted in the loss of several thousand morphine tablets and ampoules.

Standards for safeguarding narcotics of the various classes are set out in our Bureau Order No. 213, which is available on request. Consult this office or the Narcotic District Supervisor for your area when in doubt regarding safeguards or when moving narcotic stocks to a new location.

Henry L. Giordano
Commissioner of Narcotics

emption. Its educational programs and benefits are not so restricted, but are available to the public generally, and it is the availability of benefits that is relevant to the issue of tax exemption.

Bloomfield v. Academy of Medicine of New Jersey, 221 A.2d 15 (N.J., June 27, 1966).

Physician Required to Answer Certain Pretrial Interrogatories—In a suit for damages against a physician and a hospital by an infant patient for injuries caused by the allegedly negligent administration of an exchange transfusion, a trial court's order requiring the physician to answer pretrial interrogatories propounded by the patient was substantially correct, a New Jersey intermediate appellate court ruled. However, the physician could not be required to answer certain of the interrogatories.

The statutory authorization of pretrial discovery is not limited to matters relevant to the issues of the case. It permits discovery of all matters relevant to the subject matter involved in the case. One matter which is relevant to the subject matter of a case, as distinguished from its issues, is the credibility of a party. In every suit against a physician for professional negligence, his knowledge and skill are necessarily in issue. The physician will most probably take the stand and testify that his acts in treating the patient were necessary and proper. Thus, questions as to his education, training, professional affiliations, writings and experience with similar cases were clearly relevant. The physician could also be required to answer questions as to the books available in his library and in the hospital library on the subject of exchange transfusions, so that his knowledge and expertise as a specialist could be explored on cross-examination.

The physician was required to answer questions as to what he did and why, what he observed, and what happened in the course of or as a result of the procedure he followed. That the questions may call for an expression of opinion is not grounds for an objection because they deal with his specialty and his own procedure. However, he could not be required to answer questions as to whether he acted as an employee of the hospital in treating the patient and whether the injuries would have occurred in the absence of negligence because they called for legal conclusions.

The physician was required to answer questions as to the titles, degrees, and professional society membership of all expert witnesses to be used at the trial. The answers will facilitate the investigation of the witnesses' qualifications. However, the physician was not required to answer questions as to the names and addresses of all experts who have rendered an opinion or whose opinion is available to him in the suit, or questions about such opinions. The information called for by those questions is within the "work product" exclusion of the statute. The physician was required to answer questions as to the texts or treatises which will be used by his expert witnesses or by him in his cross-examination of the patient's expert witnesses. Knowing in advance what tests or treatises are to be used will save much time at the trial.

The physician was not required to tell the name of his insurer or to furnish the patient with a copy of the insurance policy. The statute limits discovery to whether insurance exists and, if so, the policy limits.

Myers v. St. Francis Hospital, 220 A.2d 693 (N.J., June 3, 1966).

New Trial Ordered on Issue of Damages in Transfusion Case—In a suit against a hospital by a patient for injuries caused by a transfusion of incompatible blood, a new trial, on the issue of damages, was ordered by a New York intermediate appellate court. It was clearly established that the patient was given the wrong type of blood. He alleged that the transfusion caused severe permanent injuries, including retinal arteriosclerosis and encephalopathy. The jury's verdict, insofar as it rested on a finding that there was a causal relationship between the wrongful transfusion and the injuries, was contrary to the greater weight of the evidence. There was, therefore, nothing in the record to support a substantial verdict.

Dorsey v. Knickerbocker Hospital, 271 N.Y.S.2d 727 (N.Y., June 30, 1966).

Suit for Leaving Sponge in Body not Barred by Statute of Limitations—A suit for damages against a hospital by a patient for injuries caused by a sponge left in his body following surgery was not barred by the three-year malpractice statute of limitations, where the suit was brought within three years after he discovered that the sponge had been left in his body, the Montana Supreme Court ruled.

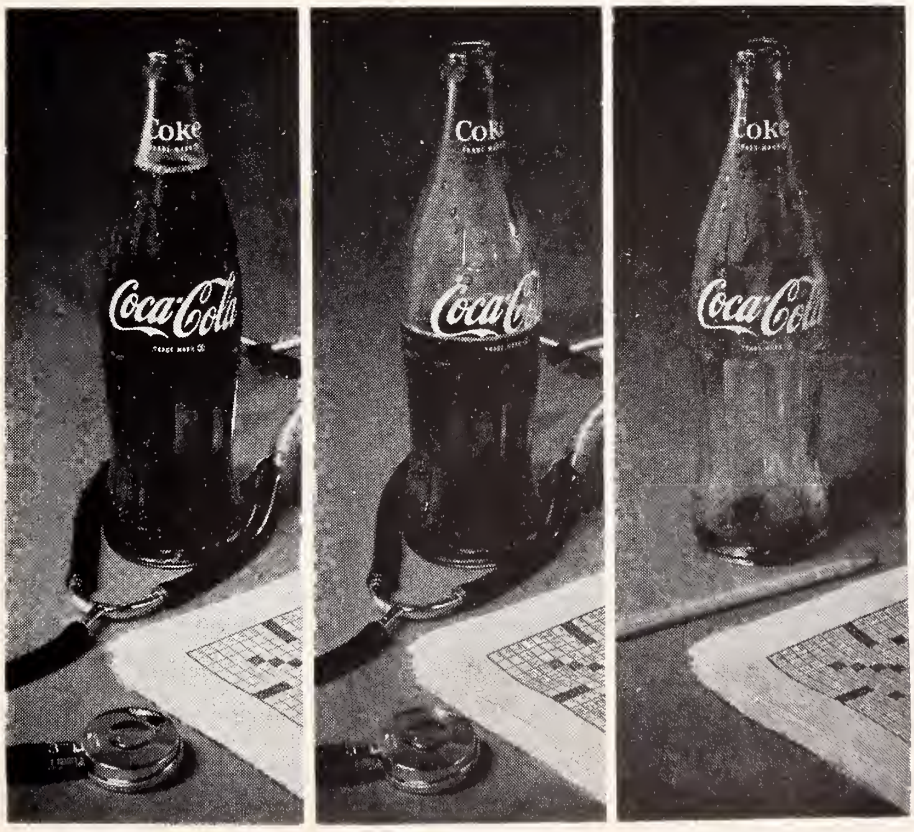
It had, in previous cases, followed the so-called "general rule" that the statute of limitations begins to run when the foreign object is left in the patient's body, the court said. Three exceptions to the "general rule" have been recognized. They are: (1) the continuing negligence theory under which the statute of limitations does not begin to run until the physician-patient relationship is terminated; (2) the contract theory under which the patient's complaint is framed in contract to get the benefit of the longer limitation period applicable to contract suits; (3) the fraudulent concealment theory under which the statute does not begin to run until the patient learns, or reasonably should have learned, that the foreign object was left in his body. A study of the cases discloses that the exceptions have been recognized in order to avoid the injustice that would result from applying the "general rule." The "general rule" has little to recommend it, and it is apparently no longer followed in a majority of jurisdictions. It would apply the rule that the statute does not begin to run until the patient knows, or reasonably should know, that the foreign object was left in his body, the court said.

Johnson v. St. Patrick's Hospital, 417 P.2d 469 (Mont., Aug. 8, 1966).◄

INDIANA STATE BOARD OF HEALTH

MONTHLY REPORT—October, 1966

Disease	Oct. 1966	Sept. 1966	Aug. 1966	Oct. 1965	Oct. 1964
Animal Bites	753	931	1038	711	896
Chickenpox	92	45	53	85	205
Conjunctivitis	65	62	158	89	124
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	62	54	44	46	237
Gonorrhea	421	501	474	347	262
Impetigo	188	214	221	224	198
Infectious Hepatitis	35	41	21	35	43
Infectious Mononucleosis	72	46	31	43	47
Influenza	509	280	137	739	911
Measles (Rubeola-Rubella)	71	74	94	212	158
Meningitis, Meningococcal	3	5	7	4	4
Meningitis, Other	3	9	4	7	8
Mumps	109	53	59	60	173
Pertussis (Whooping Cough)	6	17	23	4	50
Pneumonia	146	86	136	329	242
Poliomyelitis	0	0	0	0	2
Streptococcal Infection	348	312	265	462	497
Syphilis					
Primary & Secondary	6	7	13	6	9
All Other Syphilis	52	101	94	65	118
Tinea Capitis	13	3	12	5	47
Tuberculosis (Active)	98	88	83	96	120



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ABSTRACTS

BOOK REVIEWS

STEREOSCOPIC ATLAS OF MASTOIDOTYMPANOPLASTIC SURGERY

Schuknecht-Chasin-Kurkjian (Massachusetts Eye and Ear Infirmary), The C. V. Mosby Company, St. Louis, 1966.

This is an atlas mainly for otolaryngology residents and presents concisely for the first time the proper procedure for the examination of patients and the criteria necessary for their selection for surgery. The chapter on histopathology of chronic otitis media is complete and has beautiful photomicrographs. My only objection is the presentation of the theory of metaplasia of the middle ear mucosa into squamous epithelium.

The surgical technic described and illustrated is that employed at the Massachusetts Eye and Ear Infirmary, is conservative and one that is well adapted to the teaching of residents. Because of this conservatism, it is not a technic entirely compatible with the teachings of the House group.

The stereo reels and viewer are excellent and while quite generous, left me with the feeling I should have liked more. There are excellent sections on obtaining and mounting temporal bones and the protocol for temporal bone dissection as practiced in this training program.

DAVID E. BROWN, M.D.
Indianapolis

ARTIFICIAL LIMB WEARERS

Hanger Limbs are being successfully worn by amputees of all ages. David Canfield, just 13 months (illustrated), is one of the many young children growing up on Hanger Legs. In contrast, Captain W. T. Traylor, over 75 (illustrated), now wears his fifth Hanger. He is a fire inspector who must cover continually hospitals, schools, sports events, etc., and be on his feet for hours at a time.

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FERMENT IN MEDICINE: A STUDY OF THE ESSENCE OF MEDICAL PRACTICE AND ITS NEW DILEMMAS

Richard M. Macgraw, W. B. Saunders & Co., Philadelphia, 1966; 273 pages with illustrations; $6.50.

This little monograph gathers together, almost too compactly, many ideas that are being increasingly advanced not only by the leaders of our profession but also by many articulate members of groups ancillary to medicine. After all, the M.D.'s compose only some 10% of the 2.6×10^6 people engaged in the health industry, at present the third largest in the United States.

Not too long ago, there was the direct relationship between the sick individual and the physician of his free choice. The patient-doctor colloquium had almost a magical halo of sanctity woven around it. Today, there is increasing group practice; clinics are mushrooming; medical *schools* are becoming medical *universities* turning out specialists more interested in *Diseases* rather than in diseased *Individuals*. Laboratory tests are mushrooming into veritable procedures requiring extremely expensive, hospital set-ups and highly trained paramedical personnel to ride herd on them and try to derive the appropriate sophisticated conclusions.

Automation is taking over. The basic *social contract* between doctors and patients is in the daily process of being re-negotiated. The author concludes with an appeal to his fellow doctors to stop sighing for the past: he calls for an acceptance of the present and for realistic leadership in molding the future. Whether we agree with the argument or not — it is most refreshingly thought-provoking. Every doctor in this land of ours owes it to himself to at least scan through it. It may well be that we could emulate the Europeans in trying to train paramedical personnel to perform many duties now customarily performed by us. That would leave the doctor time to be the leader of the team. Dr. Macgraw deserves kudos for his labors; the publisher is to be commended for the excellent printing job and the modest cost.

ARNOLD LIEBERMAN, M.D.
New York, N. Y.

CARING FOR THE AGED

Bertram B. Moss, Doubleday & Company, New York, 1966; 372 pages; $4.95.

The advances in medical science have tremendously increased the older segment of our population. This large group has attracted the attention and stimulated the interest of physicians, sociologists, and also of people who have aging parents. This timely book is written for all who care for the aged—physicians, nursing home attendants and for general lay information. The aging person himself can derive much direction and satisfaction from this book.

The author is a physician who has taken special interest in the care of the aged. He has been a general practitioner of medicine and a medical director of a nursing home for the aged for many years. The information presented is medically authentic, generally reliable and is presented in a manner suitable for professional or lay reading. It covers the nature and management of the more common physical disabilities of the aged and such topics as—financial matters; insurance; retirement; housing; remarriage; emotional disturbances and terminal illness.

Anyone concerned with caring for the aged will get much useful medical and nonmedical information from this book. It is not a medical text, but has much concise information for physicians who treat older patients. It is clearly written. Even the lay reader will have no trouble understanding the material, much of which pertains to medical care.

DAVID A. BICKEL, M.D.
South Bend

HASHISH — Its Chemistry and Pharmacology

Edited by G. E. W. Wolstenholme & J. Knight, Ciba Foundation Group No. 21, Little, Brown & Co., Boston, Mass., 1965; 96 pages; $2.95.

Hashish comes from Cannabis sativa; other names are marijuana, "pot", charas, bhang, gunjah, dagga — or what have you. While not as really addicting as opiates, it is certainly the most widely used (and abused) substance in the illicit traffic of today. Tetrahydrocannabinol is the most active ingredient in the resin mixture; even more potent synthetics can be derived from the parent substance.

Whether habit-forming or addiction producing, our word, assassin, comes from the use made of this substance by a 13th century leader of a deviant Mohammedan sect.

This little study is not as compellingly interesting as it could have been. It does go into some detail on the importance of the exposed *individual:* race, religion, sex, age, family history, past medical history, occupation, vocation and marital status.

This booklet can be recommended for the less scholarly reader; it can entertain and even instruct.

ARNOLD LIEBERMAN, M.D.
New York, N. Y.

FUNCTIONS OF THE CORPUS CALLOSUM

Ciba Foundation Study Group No. 20, edited by E. G. Ettlinger, Little, Brown & Co., Boston, Mass., 1965; 156 pages; $3.75.

As the best known (as well as the largest) commissure of the CNS, the corpus callosum has been extensively studied in all animals possessing a neocortex. It is man who has this structure in its most complex form. It mediates inter-hemispheric transmission of such skills as memory, left-right orientation, reading, visual and auditory sensations, etc.

There are technical studies depicting the results of its agenesis or destruction by trauma or tumor. The neurologist will be interested in the anatomic and neurophysiological aspects of the corpus callosum as studied experimentally in primates and illustrated by reports in actual patients.

This little monograph would grace the shelves of a hospital library and the book-stand of the specialist in the field.

ARNOLD LIEBERMAN, M.D.
New York, N. Y.

Abstracts From Various Literature, Prepared by AMA

RESUSCITATION FOR CARDIAC ARREST DUE TO MYOCARDIAL INFARCTION

W. J. Grace (153 W. 111th St., New York) and W. F. Minoque
Dis. Chest 50:173-175, (Aug.), 1966.

The results of attempted cardiac resuscitation of 108 patients who had cardiac arrest from acute myocardial infarction are presented. Resuscitation was successful in 34, there was limited survival in 19 and long-term survival in 15. These patients were not on a special care unit, nor were they monitored.

INEFFECTIVENESS OF PROPHYLACTIC ANTIMICROBIAL DRUGS IN SURGERY

R. C. Karl et al. (Bellevue Hosp., New York)
New. Eng. J. Med. 275:305-308, (Aug. 11), 1966.

A double-blind study of the effect of prophylactic antimicrobials on postoperative infectious complications in patients undergoing 150 surgical procedures was carried out, using large parenteral doses of methicillin and chloramphenicol given immediately before, during, and immediately after operation. Wound infections were no less common in the patients receiving antimicrobial agents (18.5%) than in the placebo group (12.9%). The chemotherapeutic regimen similarly failed to influence significantly the incidence of postoperative pulmonary infectious complications or other miscellaneous infections. This failure of antimicrobial prophylaxis persisted when patient groups were evaluated according to type of operation. In general, organisms having similar antimicrobial sensitivities accounted for wound infections in the patients receiving placebo and in those receiving drugs.

SURGICAL TREATMENT OF ULCERATIVE COLITIS

A. Sanderud (Rikshospitalet, Oslo)
T. Norske. Laegeforen. 86:981-985, (July 1), 1966.

The surgical treatment of 82 patients with ulcerative colitis and the results of the various treatment groups are discussed and compared. Except for a small number of patients with strict segmental localization of the disease, a conservative surgical procedure has delayed the cure of the patients and additional operations were needed. Of the two main groups treated with radical surgery, those with ileostomy and pan-proctocolectomy had a much better result than the ileoproctostomy group. Patients with ulcerative colitis who do not improve satisfactorily on medical management should have an ileostomy and pan-proctocolectomy carried out in one stage.

ABSENCE OF PROPHYLACTIC EFFECT OF LINOLENIC ACID IN PATIENTS WITH CORONARY HEART DISEASE

C. F. Borchgrevink et al. (Ulleval Hosp., Oslo)
Lancet 2:187-189, (July 23), 1966.

In two groups of 100 male patients with coronary heart disease the effects of 10 ml linseed oil (50% linolenic acid) daily and of 10 ml corn oil (1% linolenic acid) daily, respectively, were compared in a double blind study; the observation period varied between three and 16 months, the average being 10 months. Serum cholesterol was reduced in both groups: 12 mg/100 ml in the linseed-oil group and 25 mg/100 ml in the corn-oil group. About 30% of the patients had congestive heart failure, but there was no difference in the two groups. Cardiac deaths per year were 12.0% in the linseed-oil group and 15.4% in the corn-oil group; the reinfarction rate was 19.4% and 15.4%, respectively. There were 21 cardiovascular episodes in the linseed-oil group (25.4%) against 18 in the corn-oil group (23.1%). Daily intake of 10 gm linseed oil reduced neither the platelet adhesiveness, nor the mortality, nor the reinfarction rate.

INTESTINAL OBSTRUCTION DUE TO ORANGE PULP IN A PATIENT WITH PARTIAL GASTRECTOMY, VAGOTOMY AND GASTROJEJUNOSTOMY

N. Riegel (USAF Hosp., Keesler AFB, Biloxi, Miss.)
Amer. Surg. 32:407-409, (June), 1966.

A patient with a subtotal gastrectomy, complete vagotomy and Billroth II gastrojejunostomy is presented who suffered distal jejunal obstruction secondary to an orange pulp bezoar requiring enterostomy for correction. Published reviews of the literature of phytobezoars in general and in partial gastrectomized patients are mentioned. That this is not a benign complication is evidenced by the 16% mortality reported in intestinal obstruction due to phytobezoar and by the very stormy postoperative course suffered by the patient reported. ◄

INDIANA UNIVERSITY SCHOOL OF MEDICINE FUND KICKS OFF 1966 CAMPAIGN

The 1966 campaign of the Indiana University School of Medicine Fund is now underway, and alumni and friends are being given another opportunity to contribute to help meet the needs of the School of Medicine. The fund program is now in its third year under the sponsorship of the Medical Alumni Association, the staff of the school and the Indiana University Foundation.

Dr. Ritchey

The sponsors of the program were most gratified when Dr. J. O. Ritchey of Indianapolis accepted the national chairmanship of the 1966 campaign. Local chairmen have now been appointed in 200 cities throughout the country. Ninety-one of these communities are in the state of Indiana. Dr. Earl W. Mericle is chairman for Indianapolis where there are more than 800 graduates of the Indiana University School of Medicine. Dr. Mericle will work with a committee of 110 local alumni. Personal solicitation is now underway.

Dr. Ritchey recently sent out a booklet describing the needs of the school and reporting the specific uses which are being made from annual contributions. It points out that donations may be made without restriction; or that they may be designated for such purposes as the John D. VanNuys Memorial Fund, the Cyrus J. Clark Memorial Loan Fund, the Faculty Scholarship Fund, the Paul Harmon Scholarship Fund or the Betsey A. Barton Fund for Neurological Research; or gifts may be earmarked for other special uses as the donor wishes.

Class secretaries will write directly to their classmates in the near future and it is anticipated that contributions will be received from every class. A friendly rivalry has developed. On Alumni Day, last May 12, awards were given to the Class of 1933 for the largest total contribution and to the Class of 1914 for the highest percentage of participation.

In last year's campaign of the School of Medicine Fund more than $75,000 was received from nearly 1,200 donors representing some 370 communities throughout the nation. There were more than 200 gifts from non-graduates of the school, many of whom were physicians in the state with degrees from other institutions. These statistics relate only to gifts from alumni and friends resulting directly from the campaign conducted by the Indiana University Foundation in cooperation with the Medical Alumni Association.

The figures do not include gifts and bequests for the benefit of the School of Medicine which are made directly to Indiana University rather than through the foundation. Neither does the total include donations which many graduates assign to their alma mater through the American Medical Education Foundation of the American Medical Association. The School of Medicine, of course, is equally grateful for all gifts received from all sources.

Information on the fund is available through the Indiana University Foundation, Memorial Union Building, Bloomington.

Dr. John Stetson Speaker for John Shaw Billings History of Medicine Society

Dr. John B. Stetson, assistant professor of anesthesiology at the Indiana University Medical Center, will be guest speaker at the February 9 meeting of the John Shaw Billings History of Medicine Society.

Dr. Stetson's topic will be "The Webster-Parkman Murder Case." The group meets at the I.U. Student Union Building, Indianapolis. The social hour begins at 6:00 p.m., dinner is set for 6:45 p.m. and the speaker at 8 p.m.

Lost Radiation Cylinder May be Cause of Radiation Dermatitis

A 300 mg Ra-Be radiation source, packaged in a lead pig and wooden crate, was shipped from Fort Worth, Texas, July 26, 1966, to New York City. The source, a stainless steel cylinder somewhat less than 2 cm x 2 cm, was lost from its lead container enroute.

The radiation intensity at 1 cm has been estimated to be approximately 900 R per hour and at 12 inches about 2.7 R per hour. The only identification on the cylinder is the serial number 155001 and thus it would likely not be recognized by the uninitiated as a radiation source.

Dr. A. C. Offutt, State Health Commissioner, Indiana State Board of Health, suggests that physicians consider radiation as a possibility where there are findings consistent with radiation dermatitis or bone marrow depression without an adequate etiological explanation.

Physicians should call the Radiological Health Section, Indiana State Board of Health, telephone Indianapolis 633-6340 (after hours, call 633-4360), if either firm or tentative findings of this nature are made, or if they receive other information possibly related to an unexplained radiation exposure. Expert help will be provided to perform the investigations which may be needed.

Dr. J. H. Walsh Completes Residency

Dr. J. H. Walsh has recently completed residency training in radiology at the Mayo Graduate School of Medicine and will practice his specialty in Fort Wayne.

New Fellows Named by American College of Surgeons

The American College of Surgeons conferred Fellowship on the Indiana surgeons listed below at its Annual Clinical Congress in San Francisco recently.

Those honored were Drs. John F. Lawler, Evansville; Robert R. Shugart, Fort Wayne; John E. Moenning, Greenfield; Nicholas L. Polite, Hammond; Wayne S. Miller, Huntington; E. Dale Habegger, Russell L. Judd, Robert M. Palmer and Jack K. Riner, Indianapolis;

Rodney A. Maunion and Edward A. Mladick, Michigan City; Lawrence J. Lawson, Muncie; Eudell G. Paul, Munster; Melvin D. Cook, New Albany; Robert P. Inlow, Shelbyville and Rafael Macias, South Bend.

Dr. Raber Attends Meetings

Dr. Robert M. Raber recently gave a paper entitled "Surgery of the Rheumatoid Hand" before the Plastic Surgery Section of the International College of Surgeons in Oaxaca, Mexico.

He also attended the Latin American Congress of Plastic Surgery while in Mexico City. "On the way home," he attended the annual meeting of the American Society of Plastic and Reconstructive Surgeons which was held in Las Vegas, Nevada.

"Ability Counts" Contest Sponsored By Commission for the Handicapped

The Commission for the Handicapped of the Indiana State Board of Health will again sponsor an "Ability Counts" contest for 11th and 12th grade students with contest entries due at the State Board of Health offices by February 15, according to Dr. Neal E. Baxter, commission chairman, Bloomington.

Sponsored jointly by the Indiana Commission for the Handicapped and the President's Committee on Employment of the Handicapped, the contest is a combination field trip, survey, reporting and writing activity. In order to be a contestant, students will be asked to investigate, first hand, how handicapped workers in their communities are proving that "ability, not disability, counts."

They will be encouraged to make an independent field trip to employment and vocational rehabilitation offices, to talk with employers and labor officials, to contact public and private organizations providing services for the handicapped, and to interview handicapped persons to obtain the facts needed to prepare the brief report within the framework of the 1966-67 contest theme, "Handicapped Workers — Community Assets."

Judges for Indiana's contest will be: Donald F. Moore, M.D., Medical Director, LaRue D. Carter Memorial Hospital; Raymond E. Warden, Head of English Department, Indiana Central College; Judy Williams, former news reporter for the WFBM Stations and former educational specialist for *The Indianapolis Times*. Indiana's winning entry will then be placed in national competition.

National contest judges are: Mrs. Betsy Talbot Blackwell, Editor-in-Chief, *Mademoiselle;* Carl J. Megel, Washington Representative, American Federation of Teachers, AFL-CIO; and Dr. Ivan E. Taylor, Head, Department of English, Howard University.

Five awards are made in the national contest, as follows: first place, $1,000; second, $600; third, $400; fourth, $300; fifth, $200; in addition to transportation and expenses for a trip to Washington, D.C.

In addition to the national prizes, awards for the best five state reports will be available to the students of Indiana high schools. First, a trip to Washington, D.C., plus $150 expense money; second, $125; third, $75; fourth, $50; fifth, $25.

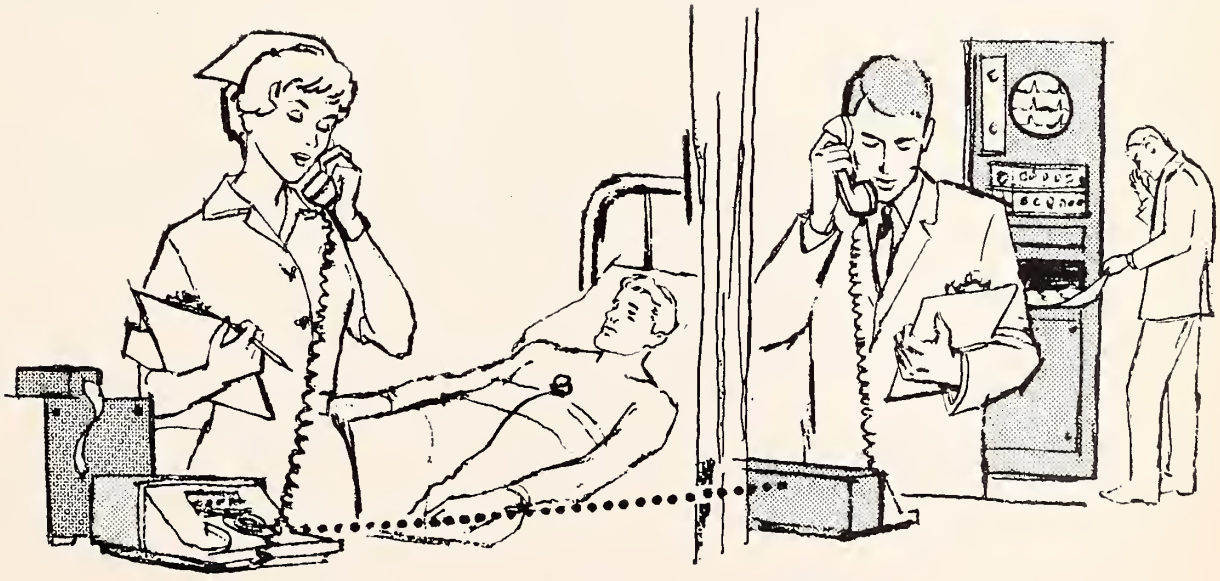
Detailed information has been sent to principals of all Indiana high schools. Further information is available upon request from the State Board of Health, Division for the Handicapped, 1330 W. Michigan St., Indianapolis 46207.

Post Office Department Authorizes Indianapolis Medical Officer Post

The Post Office Department has authorized a Medical Officer position in the Indianapolis, Indiana Post Office.

The basic function of the position is to operate a medical facility for providing authorized and necessary employee health services in the administration of this post office with approximately 4,100 employees.

Applications for the position will be accepted by C. H. Boswell,



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Public Health Service Publishes New "Obesity and Health" Pamphlet

The Public Health Service has published a booklet to assist in the treatment and prevention of one of the major health problems—obesity.

"Obesity and Health" is a compendium of current information designed to assist the health professions with the obesity problems they encounter in their respective field of activity. It was prepared by a panel of specialists and is released by the Heart Disease Control Branch, Division of Chronic Diseases.

Single copies are available free from Public Health Service, Washington, D. C. 20201. The pamphlet sells for 60 cents per copy and is available from the Superintendent of Documents, Government Printing Office, Washington, D. C. 20402.

Hospital Ship HOPE Returning To New York for Repairs, Re-supply

The Hospital Ship HOPE is now completing a ten-month mission to Nicaragua and will return to New York soon for repairs and re-supply, preparatory to sailing in early February to Colombia.

While there, the staff will conduct training programs in cooperation with the University of Cartagena School of Medicine and conduct public health education programs. Colombia will be the seventh nation visited by the ship since the People-to-People Health Foundation started its medical good-will voyages in 1960.

Dr. Irwin Delivers Address

Dr. Glenn W. Irwin, Jr., Dean of the I. U. School of Medicine, delivered the convocation address at the recent annual scientific session of the American College of Gastroenterology in Philadelphia.

Dr. Irwin discussed the Indiana University plan for future medical education in Indiana. Dr. Joseph E. Walther, Indianapolis, who is a trustee of the college, and Dr. Roger P. Bissonette, Evansville, a governor of the college, participated in the scientific sessions.

Two New Programs Initiated at Indiana University Medical Center

Two new programs important to the welfare of the state and the nation have been developed by the Indiana University Medical Center and the School of Medicine.

A Division of International Health, to promote and coordinate interaction with professionals in the health sciences in other countries, has been established by the Medical Center.

The School of Medicine has begun a new development program in preventive medicine at both the community and state levels.

Dr. Edwin W. Brown, Jr., who for the past year has been director of Project Viet Nam in Washington, D.C., will head both programs, according to Dr. Kenneth E. Penrod, provost of the I.U. Medical Center, who announced creation of the new division and Dr. Brown's appointment.

Dr. Brown will hold the title of associate professor of preventive medicine in the School of Medicine. In this capacity he will work with community agencies, such as public health and welfare, and with local physicians in establishing preventive medicine programs.

This effort will be to develop teaching programs for medical and other students and to cooperate with service health facilities in the local communities.

The new Division of International Health will have responsibility for the Medical Center's involvement with international programs both on the campus in Indianapolis and overseas.

Dr. Edwards Named

Dr. Joshua L. Edwards, chairman of the department of pathology at the University of Florida College of Medicine since 1955, has been named professor of pathology and director of the Combined Degree Program at Indiana University.

The Combined Degree Program was instituted on the Bloomington campus in 1959 as a joint enterprise of the I.U. School of Medicine, the College of Arts and Sciences and the Graduate School, with support from the Commonwealth Fund.

"The Mechanisms of Action of the Oral Contraceptives" Film Available

A new medical motion picture, "The Mechanisms of Action of the Oral Contraceptives," has been released by Syntex Laboratories.

It is a 21-minute, 16 mm, color film which presents the similarities and dissimilarities of both the combination and sequential birth control medications. The film may be obtained by physicians or medical groups from Syntex Laboratories, 3401 Hillview Ave., Palo Alto, Calif. 94304.

Dr. Holmes Appointed

Dr. Robert H. Holmes has been appointed Associate Medical Director for Ames Company, Elkhart. Dr. Holmes recently retired from the U.S. Army, with which he has spent most of his professional career as a pathologist. ◄

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* * *

The newspaper advertisements on "nuxated iron" say, "Consult your doctor and see what he says about 'nuxated iron.'" It wouldn't be a bad idea for the medical profession to publish a rejoinder to the effect that what most doctors say about "nuxated iron" would not look well in print.

* * *

San Francisco County (California) recently has passed an ordinance prohibiting the taking of wearing apparel, household goods, etc., home on approval, and merchants are not allowed to take back into stock goods of various kinds likely to suffer from contact with the person of the household and its furnishings. This is a wise action, for, with the prevalence of syphilis, gonorrhea, skin diseases, tuberculosis, contageous diseases and even vermin, this practice is anything but conducive to the advancement of public health, and other counties and states would do well to pass a similar law.—Editorial Notes, *JISMA*, December, 1916.

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Medical Director

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Administrator

Indiana Physicians to Speak At Postgraduate Texas Assembly

The 31st annual session of the International Medical Assembly of Southwest Texas will be held in San Antonio January 23, 24 and 25, 1967, at the Gunter Hotel.

Guest speakers will include Drs. A. D. Dennison, Jr. and Frank Vellios, both of Indianapolis. The program is acceptable for 15 accredited hours by the American Academy of General Practice. Further information may be obtained from Dr. John H. Bohmfalk, president, or Mr. E. S. Cockrell, Jr., executive director, 202 W. French Place, San Antonio 78212.

1967 Dates Announced for Annual Colorado Winter Clinics

The Colorado Winter Clinics will be held at the Brown Palace Hotel in Denver Tuesday through Friday, February 28-March 3, 1967. Scientific programs are planned each afternoon. Dr. Joseph Butterfield, program chairman, announced that the Yampa Valley Mail train leaves Union Station daily at 9:05 a.m. for skiing at Winter Park, Colorado, for those who wish to attend scientific meetings one day and ski another.

The February 28 program will feature "Interuterine Transfusion and the Fetus," with Dr. Alvin Zipursky of the University of Manitoba and Dr. Richard Bashore of the University of California Center for Health Sciences participating. The March 1 program will cover "Surgery of the Heart." The March 2 program will feature "The Airway," and the March 3 program "Hypertension."

Additional details about the meeting and a ski vacation in Colorado may be obtained by writing the Colorado Medical Society, 1809 E. 18th Ave., Denver, Colorado 80218. Hotel reservations may be obtained by writing to the Brown Palace Hotel, referring to planned attendance at the Colorado Winter Clinics. "Colorado Skiing," with information on resorts, services and transportation may be obtained by writing the Colorado Visitors Bureau, 225 W. Colfax, Denver.

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Postgraduate Courses on Cardiovascular Diseases Offered

An intensive program on Auscultation of the Heart, Phonocardiography and Pulse Tracings, with special emphasis on the practical clinical applications, is being offered by the Institute for Cardiovascular Diseases at Good Samaritan Hospital, 1033 E. McDowell Rd., Phoenix, Arizona on Thursday, April 6th and Friday, April 7th, 1967.

The meetings will be held at the Mountain Shadows Resort in Scottsdale, Arizona. This is an official postgraduate course of the American College of Cardiology. For more information write William D. Nelligan, Executive Director, American College of Cardiology, 9650 Rockeville Pike, Washington, D.C. 20015.

National Methodist Convention On Medicine and Theology Set

The National Methodist Convocation on Medicine and Theology will be held at Rochester, Minnesota, on April 5 to 7, 1967.

The meeting is sponsored by The Council of Bishops and Board of Hospitals and Homes, Board of Christian Social Concerns, National Division of the Board of Missions and the Commission on Chaplains in cooperation with the Rochester Methodist Hospital and the Mayo Clinic.

For full information write: National Methodist Convocation, P. O. Box 102, Rochester, Minnesota 55901.

General Practice Review Set For Entire Week in Colorado

A General Practice Review, a full week of postgraduate courses devoted to a separate general subject each day will be conducted in Denver by the University of Colorado School of Medicine, January 15 to 21, 1967.

The daily subjects are Sexual Problems, Medicine, Pediatrics, Surgery, Trauma, Obstetrics and Gynecology and Dermatology. Write the office of Postgraduate Medical Education, 4200 E. Ninth Ave., Denver 80220.

Cleveland Clinic Announces Courses in Dermatology, Surgery

The Cleveland Clinic Educational Foundation will present a postgraduate course in "Advances in Dermatology" January 11 and 12, 1967 and another on "Controversies in General Surgery" January 18 and 19 at Cleveland.

Further information and detailed programs may be obtained by writing the Director of Education, the Cleveland Clinic Educational Foundation, 2020 E. 93rd St., Cleveland, Ohio 44106. ◄

County, District News

Allen

The Fort Wayne (Allen County) Medical Society met October 4 to hear Dr. Nicholas P. Dallis, author of the comic strips "Judge Parker," "Apartment 3-G" and "Rex Morgan, M.D.," speak on "Life Among the Comic Strip Heros and Heroines." There were 198 physicians and their wives in attendance.

Dearborn-Ohio

Mrs. Delores Baker, wife of Dr. L. M. Baker, spoke on "Highlights of Local Medical History" at the October 6 meeting of the Dearborn-Ohio County Medical Society.

LaPorte

The LaPorte County Medical Society met October 18 to hear Dr. Melvin R. Cohen, of the Michael Reese Hospital Staff in Chicago speak on "Sterility."

Tippecanoe

Dr. Levine, of Chicago, discussed "Inhalation Therapy" at the October 11 meeting of the Tippecanoe County Medical Society.

Vanderburgh

Project aims, accomplishments and activities to date of "Holidays for Humanity, Inc." were discussed with color slides by Dr. John Slaughter at the October 4 meeting of the Vanderburgh County Medical Society. A group of physicians, dentists, nurses and teachers devote their vacations to work among people in remote areas in "Holidays for Humanities," an idea conceived by Dr. Slaughter.

Wayne-Union

Dr. Joseph F. Tomaschefski, of Ohio State University, spoke at the October 11 meeting of the Wayne-Union County Medical Society. His topic was "Patho-physiology of Emphysema." Thirty-three members attended. ◄

Deaths

Herbert H. Inlow, M.D.

Dr. Herbert H. Inlow, one of the founders of the Inlow Clinic at Shelbyville, died October 8 at W. S. Major Hospital there. He was 66.

A specialist in radiology, Dr. Inlow founded the clinic in 1923 with his brothers. With the exception of his military service during World Wars I and II, he had been active in the operation of the clinic since its founding. He was graduated from the Rush Medical College in Chicago in 1923 and was a member of the Shelby County Medical Society.

Eva F. Reilly, M.D.

Dr. Eva F. Reilly, anesthesiologist at St. Francis Hospital in Indianapolis, died October 17 at the age of 46.

Graduated from St. Thomas University in the Philippines in 1942, Dr. Reilly was a member of the Society of Anesthesiologists and the Marion County Medical Society.

Charles L. Richardson, M.D.

Dr. Charles L. Richardson, 63, long-time Rochester physician and surgeon, died November 3 at his office.

After being graduated from the Indiana University School of Medicine in 1927, Dr. Richardson returned to his native Rochester in 1934 to establish his practice. Prior to that, he had practiced four years at Monon. A member of the Fulton County Medical Society, Dr. Richardson served as Fulton county health officer since 1959 and was active in the establishment of a county health ordinance the same year.

James V. White, M.D.

Dr. James V. White, 55, who had practiced internal medicine and cardiology at Terre Haute for the last 30 years, died October 9 following an extended illness.

Graduated from the Indiana University School of Medicine in 1936, Dr. White was a past president of the Vigo County Medical Society and an ISMA delegate. ◄

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"'Tranquilizer' is not a good word"[1]

"THIS classification is psychologically too seductive, pharmacologically too unspecific, and in terms of results not infrequently untrue."[2]

What is a tranquilizer? According to the 24th Edition of Dorland's Medical Dictionary[3] a tranquilizer is "an agent which acts on the emotional state, quieting or calming the patient without affecting clarity of consciousness."

Defining a drug by its effects, however, can be misleading. The same effects by which the dictionary defines a tranquilizer have sometimes been seen after administration of a sedative — or, for that matter, a placebo.

Ambiguous though the term may be, it appears to be here to stay. The 1966 edition of the Physicians' Desk Reference[4] lists 42 tranquilizers indicated for treatment of anxiety and apprehensive states.

'Tranquilizers' have differences in action, differences in effect

Although all tranquilizers are intended to calm anxious patients there *are* differences in their actions — and in their effects. They have been divided into three categories — the rauwolfia group, the 'minor' tranquilizers, and the phenothiazines.[5]

Although the tranquilizing effect of rauwolfia has been known for centuries, its use as an antipsychotic agent in current practice has diminished.[5]

A 'minor' tranquilizer is often prescribed to achieve more than one effect. Thus, besides being tranquilizers some of these compounds may be muscle relaxants, antihistaminics with some calming action, anticholinergic sedatives, or antispasmodics.[5]

The phenothiazines are considered 'major' tranquilizers because they alter psychotic behavior.[1] This classification may have done them more harm than good because it implies that the phenothiazines should be reserved for the more severely disturbed. This is not necessarily true.

The phenothiazines — and the problem of sedation

One of the problems of prescribing phenothiazines for ambulatory patients has been the fear that excessive sedation will impair the patient's ability to function. This, however, is less of a problem with some of the phenothiazines.

"Clinically they may be differentiated primarily in terms of their potency and the extent of their sedative effect, which appear to be inversely proportional. That is, the least potent, the one which is used in highest dosage, chlorpromazine, is the most sedative, while the reverse holds true for fluphenazine."[6]

In a recent report on various studies conducted over several years evaluating 360 patients treated for anxiety and stress with seven phenothiazines, this inverse relationship of potency to sedation was confirmed.[7] Also under consideration was the degree to which the particular phenothiazines neutralized anxiety (the angolytic index). Interestingly enough there was, again, an inverse relationship. The most sedative of the phenothiazines appeared to be the least active in neutralizing anxiety. Fluphenazine, one of the least sedative, on the other hand, was found to be most effective in relieving anxiety.[7]

RELATIVE SEDATIVE AND ANGOLYTIC INDICES OF PRINCIPAL PHENOTHIAZINES*

DRUG	SEDATIVE INDEX	ANGOLYTIC INDEX	BASED ON STANDARD DOSE OF
Chlorpromazine	100	15	25 mgs.
Triflupromazine	100	15	25 mgs.
Thioridazine	90	17	25 mgs.
Perphenazine	15	25	4 mgs.
Carphenazine	25	25	25 mgs.
Trifluoperazine	3.3	95	2.0 mgs.
Fluphenazine	3.5	100	2.5 mgs.

*adapted from Sainz[7]

Prolixin is therapeutically effective without excessive sedation

When used as a 'tranquilizer' in general medical practice, in many patients Prolixin (Squibb Fluphenazine Hydrochloride) suppresses anxiety, but not normal activity. These two features are of particular importance to patients who must be able to live and work without their normal daily activities being restricted.

Because of its longer duration of action, Prolixin, in doses of as little as one to three milligrams in adults, generally taken once a day, is effective in maintaining many patients free of their symptoms of anxiety and tension.

Contraindications: Do not use with high doses of hypnotics or in patients with subcortical brain damage. Use with caution in patients with a history of convulsive disorders. Severe reactions may occur in patients with idiosyncrasy to other centrally-acting drugs, and severe hypotension may occur in patients with special medical disorders, e.g. mitral insufficiency and pheochromocytoma.

Precautions: Effects of atropine, anesthetics and C.N.S. depressants may be potentiated. Hypotension may occur in patients undergoing surgery. Do not use epinephrine for treatment of the hypotensive reactions which may appear in patients on phenothiazine therapy.

Side Effects: Extrapyramidal reactions, allergic skin reactions, the possibility of anaphylaxis, drowsiness, visual blurring, dizziness, insomnia, nausea, anorexia, salivation, edema, perspiration, dry mouth, abnormal lactation, polyuria, hypotension, and jaundice and biliary stasis may occur. Routine blood counts are recommended to determine possible blood dyscrasias; if symptoms of upper respiratory infection occur, discontinue drug and institute appropriate therapy.

Available: 1 mg. tablets. Bottles of 50 and 500.

For full prescribing information, see package insert.

References: 1. Simpson, G.M.: Postgrad. Med. *39*:557, 1966. 2. Freyhan, F.A.: Am. J. Psychiat. *115*:577, 1959. 3. Dorland's Illustrated Medical Dictionary, ed. 24, Philadelphia, W. B. Saunders Co., 1965, p. 1603. 4. Physicians' Desk Reference, 1966, Oradell, N.J., 1965, p. 310. 5. Cohen, S.: Northwest Med.: *65*:197, 1966. 6. Detre, T., and Jarecki, H.: Connecticut Med. *25*:553, 1961. 7. Sainz, A.: Psychosomatics *5*:167, 1964.

PROLIXIN®

SQUIBB FLUPHENAZINE HYDROCHLORIDE

block end runs

LOMOTIL®

tablets/liquid

® Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride..... 2.5 mg.
(Warning: May be habit forming)
atropine sulfate .....0.025 mg.

tackles the problem of diarrhea directly

Effectiveness—Physiologic evidence indicates that Lomotil acts directly on the smooth muscle of the bowel to lower motility and control diarrhea. This action is unsurpassed in promptness and efficiency.

Convenience—Lomotil is available as small, easily carried, virtually tasteless tablets and as a pleasant, fruit-flavored liquid.

Versatility—The therapeutic efficiency, safety and convenience of Lomotil may be used to advantage alone or adjunctively in diarrhea associated with:

• Functional hypermotility • Acute infections • Malabsorption syndrome • Drug therapy • Gastroenteritis and colitis • Irritable bowel • Regional enteritis • Ileostomy • Ulcerative colitis • Food poisoning

For correct therapeutic effect
Rx correct therapeutic dosage

Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are:

Children: Total Daily Dosage

3-6 mo. . .½ tsp.* t.i.d. (3 mg.)
6-12 mo. .½ tsp. q.i.d. (4 mg.)
1-2 yr. . . .½ tsp. 5 times daily (5 mg.)
2-5 yr. . . .1 tsp. t.i.d. (6 mg.)
5-8 yr. . . .1 tsp. q.i.d. (8 mg.)
8-12 yr. . .1 tsp. 5 times daily (10 mg.)

Adults: 2 tsp. 5 times daily (20 mg.)
(or 2 tablets q.i.d.)

*Based on 4 cc. per teaspoonful.

Maintenance dosage may be as low as one-fourth the initial daily dosage.

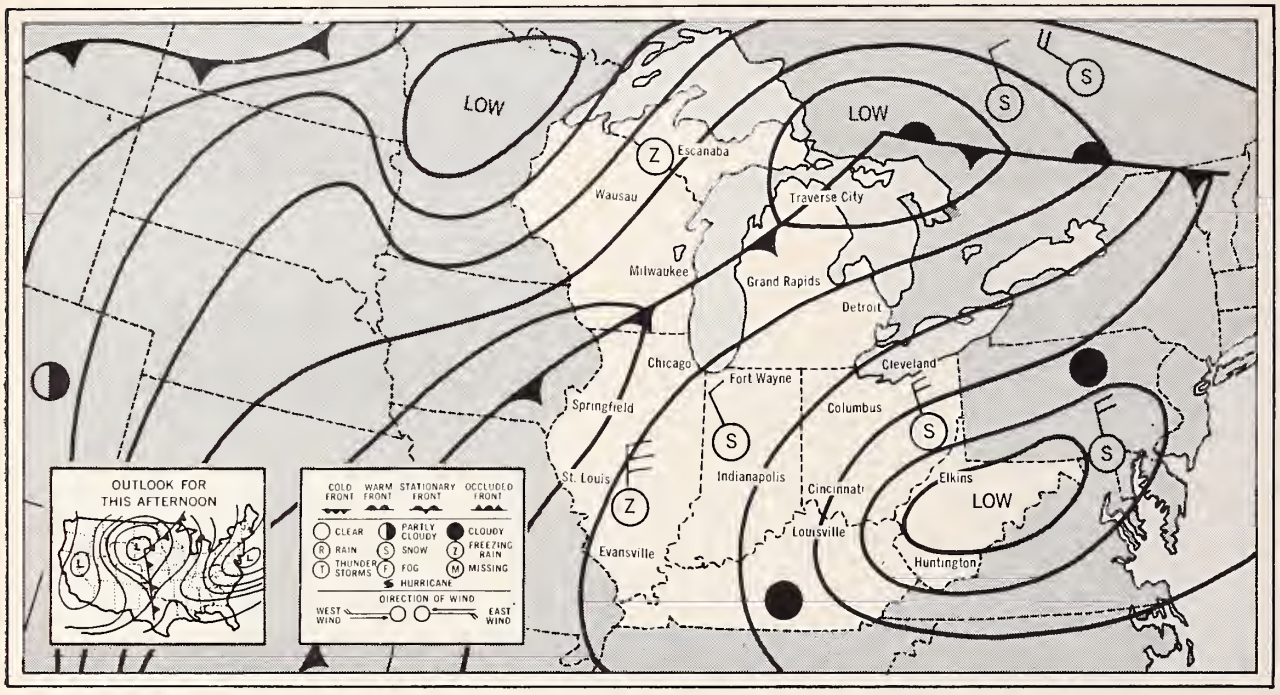
Precautions: Lomotil, brand of diphenoxylate hydrochloride with atropine sulfate, is a Federally exempt narcotic preparation of very low addictive potential. Lomotil should be kept out of reach of children since accidental overdosage may cause severe respiratory depression. Recommended dosages should not be exceeded. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates. The subtherapeutic amount of atropine is added to discourage deliberate overdosage.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness, insomnia, numbness of extremities, headache, blurring of vision, swelling of the gums, euphoria, depression and general malaise.

SEARLE *Research in the Service of Medicine*

REGIONAL WEATHER FORECAST

Severe Snow Storms, Strong Winds and Bitter Cold Followed by Cough, Stuffed and Runny Noses and Aches and Pains.



Tussagesic breaks up coughs, quickly clears stuffed and runny noses and relieves aches and pains. Provide coverage of the tough cold for up to 24 hours with just a single timed-release tablet dosed morning, midafternoon and at bedtime.

each

Tussagesic®

timed-release tablet contains:

Triaminic® (phenylpropanolamine hydrochloride 25 mg., pheniramine maleate 12.5 mg., pyrilamine maleate 12.5 mg.)	50 mg.
Dextromethorphan hydrobromide	30 mg.
Terpin hydrate	180 mg.
Acetaminophen	325 mg.

Dosage: Adults—1 tablet, swallowed whole to preserve timed-release feature, in morning, midafternoon and at bedtime. *Side effects:* Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. *Precautions:* The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

DORSEY LABORATORIES · *a division of The Wander Company* · **LINCOLN, NEBRASKA**

ENJOYING a ride in the "surrey with the fringe on top" are Dr. and Mrs. William Anshutz and Dean and Mrs. Glenn W. Irwin, Jr., all of Indianapolis.

1966-The Convention Story

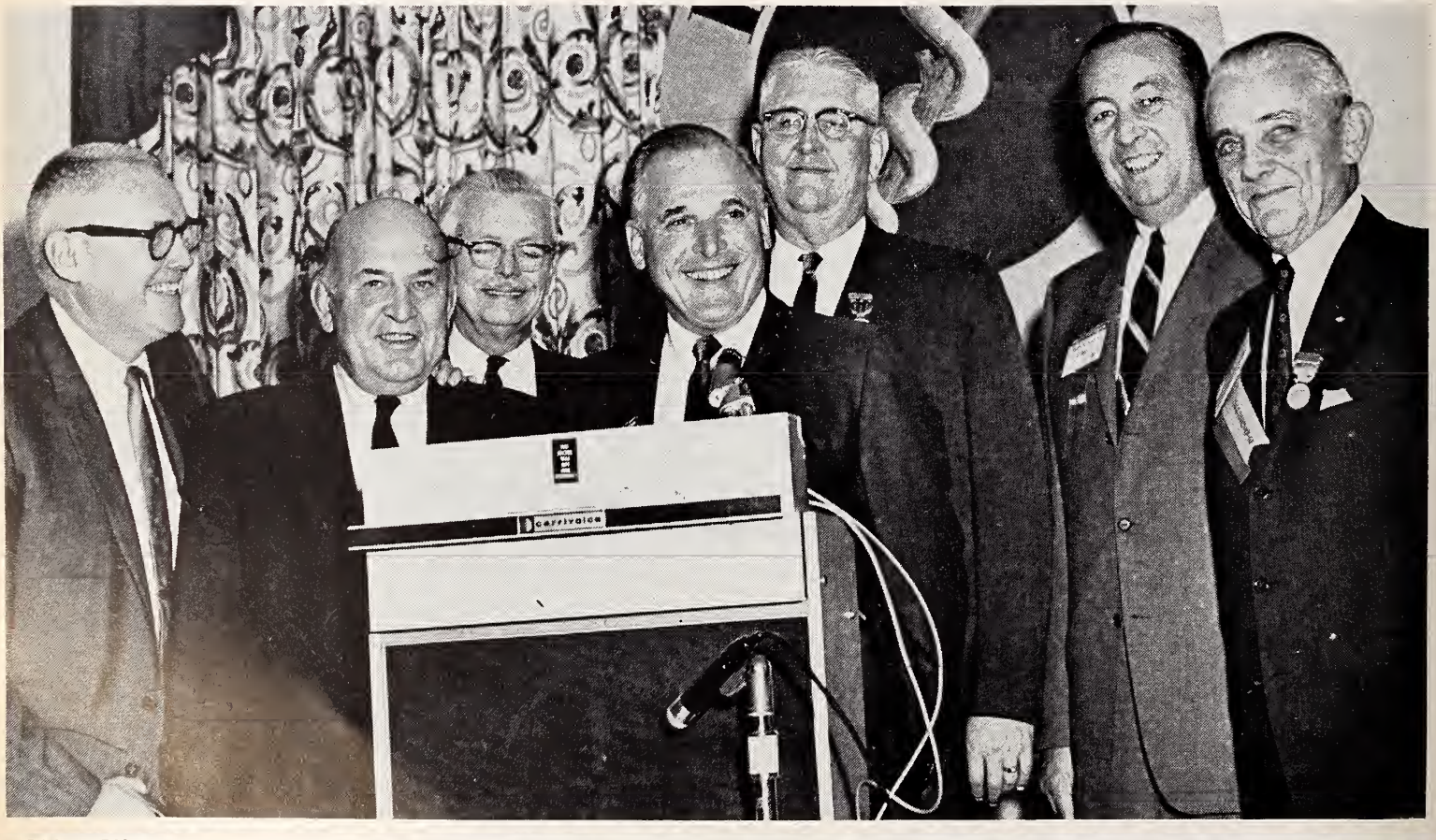
THE COUNCIL met each morning to discuss important matters concerning the convention and the ISMA.

TECHNICAL EXHIBITORS spent many hours explaining their new products to the physicians attending the convention.

DR. JOHN KARN, South Bend, prepares to fire in the Trap and Skeet Shoot as Dr. Claude Donahue, Carmel, chairman of the shoot, looks on.

THE ANNUAL GOLF TOURNAMENT attracted many physicians. Here Dr. William H. Cripe, Portland, tees off as Drs. J. S. Fitzpatrick, Forrest J. Babb and Gene E. Ress await their turn.

SCIENTIFIC EXHIBITS are a point of interest at every convention. Dr. Herbert P. Hargett, Jeffersonville, explains his entry to (left to right) Drs. John L. Arbogast, Indianapolis; Richard B. Hovda, Evansville and Lall G. Montgomery, Muncie.



PAST-PRESIDENTS OF ISMA gathered for an annual luncheon and then attended a House of Delegates meeting. Gathered 'round the rostrum are (left to right) Drs. Maurice E. Glock, Fort Wayne; Earl W. Mericle, Indianapolis; M. C. Topping, Terre Haute; Don E. Wood, Indianapolis; K. O. Neumann, Lafayette; Joe M. Black, Seymour and Guy A. Owsley, Hartford City.

HATS draw the attention of any woman and a "hat bar" in the hotel lobby was constantly crowded.

HOUSE OF DELEGATES members listen attentively to the proceedings of their first meeting Monday afternoon in North Convention Hall.

THE ART AND HOBBY SHOW is another convention highlight. Dr. William Harlan, Evansville, (right) shows his prize-winning sculpture to Dr. Gilbert Wilhelmus, also of Evansville.

WINNERS of the sports trophies line up with their awards after presentation at the Stag Party.

THE SUPPER, SMOKER AND STAG PARTY was well attended in the Main Dining Room of the French Lick-Sheraton Hotel. Dr. Guy B. Ingwell, Knox and Dr. Harold D. Lynch, Evansville, go through the buffet line prior to the entertainment.

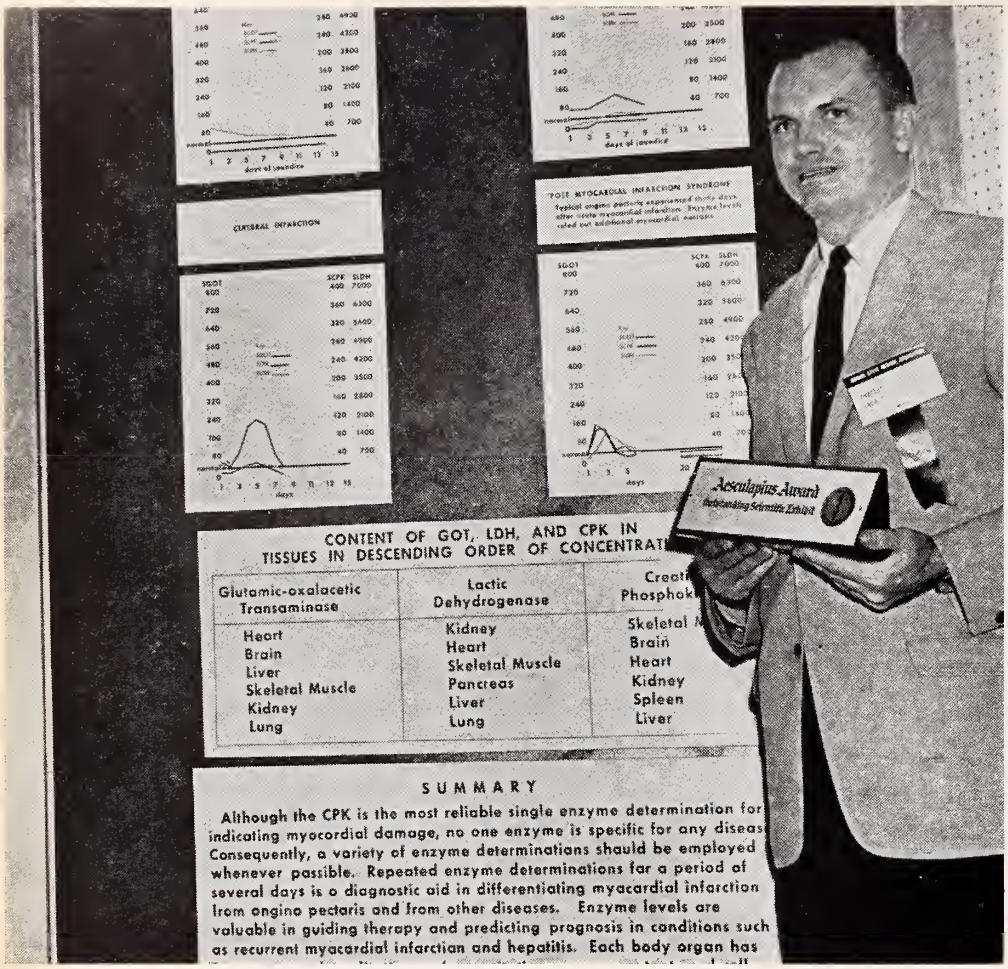
DR. ELEANOR ALEXANDER-JACKSON was the principal speaker at the women physicians' dinner meeting Monday evening in the Terrace Room.

THE WOMAN'S AUXILIARY met for dinner Monday night in the West Dining Room.

FIRESIDE CONFERENCES on Cardio-Respiratory Diseases drew the usual crowds for the meeting Monday evening.

REFERENCE COMMITTEES worked long and arduous hours discussing the various resolutions submitted by the county medical societies. This picture is of the Reference Committee on Insurance.

THE FLYING PHYSICIANS ASSOCIATION met for their annual convention get-together Tuesday afternoon.



DR. CHARLES R. ELLIS proudly displays the Aesculapius Award which was awarded his scientific exhibit on "Serum Enzyme Patterns as Diagnostic Aids." The exhibit also won first place in the ISMA awards.

"IMMUNIZATION" was the topic of the Tuesday afternoon joint scientific meeting.

THE WOMAN'S AUXILIARY was forced indoors by the cool weather at French Lick so they played bridge and canasta on the Mezzanine.

"THE SINGING DOCTORS" had everyone literally in "stitches" at the President's Night Dinner in the Main Dining Room.

SMALL COUNTY DELEGATES met Wednesday morning in the West Dining Room for breakfast.

SECTION MEETINGS are always well attended at any convention. The Section on General Practice met in Parlors D and E on Wednesday to listen to speakers and elect new officers.

FIFTY-YEAR CLUB MEMBERS gathered for their traditional glass of champagne and reception Wednesday noon.

THE PRESIDENT'S RECEPTION in the Formal Gardens was held in a beautiful setting. Dr. Frank B. Ramsey, editor of The Journal, greets Dr. K. O. Neumann, president of ISMA, in the receiving line.

THIS OVERALL shot of the reception shows the crowd which attended the event to honor Dr. Neumann.

STOPPING off for a sip of the world-famous Pluto water are Dr. and Mrs. Donald Kerr, Bedford, and their party.

SCIENTIFIC EXHIBIT winner Dr. Harley P. Palmer accepts his first place award from Dr. Richard B. Hovda, chairman of the exhibits.

SECOND PLACE winner in the scientific awards category was Dr. Wei-Ping Loh, Gary.

THIRD PLACE winner in the scientific awards was Dr. Thomas A. Arnold of the Indiana University Medical Center.

MRS. HELEN RYAN, Director of Public Affairs for television station WTHI-TV, Terre Haute, accepts the ISMA public relations award from Dr. Neumann.

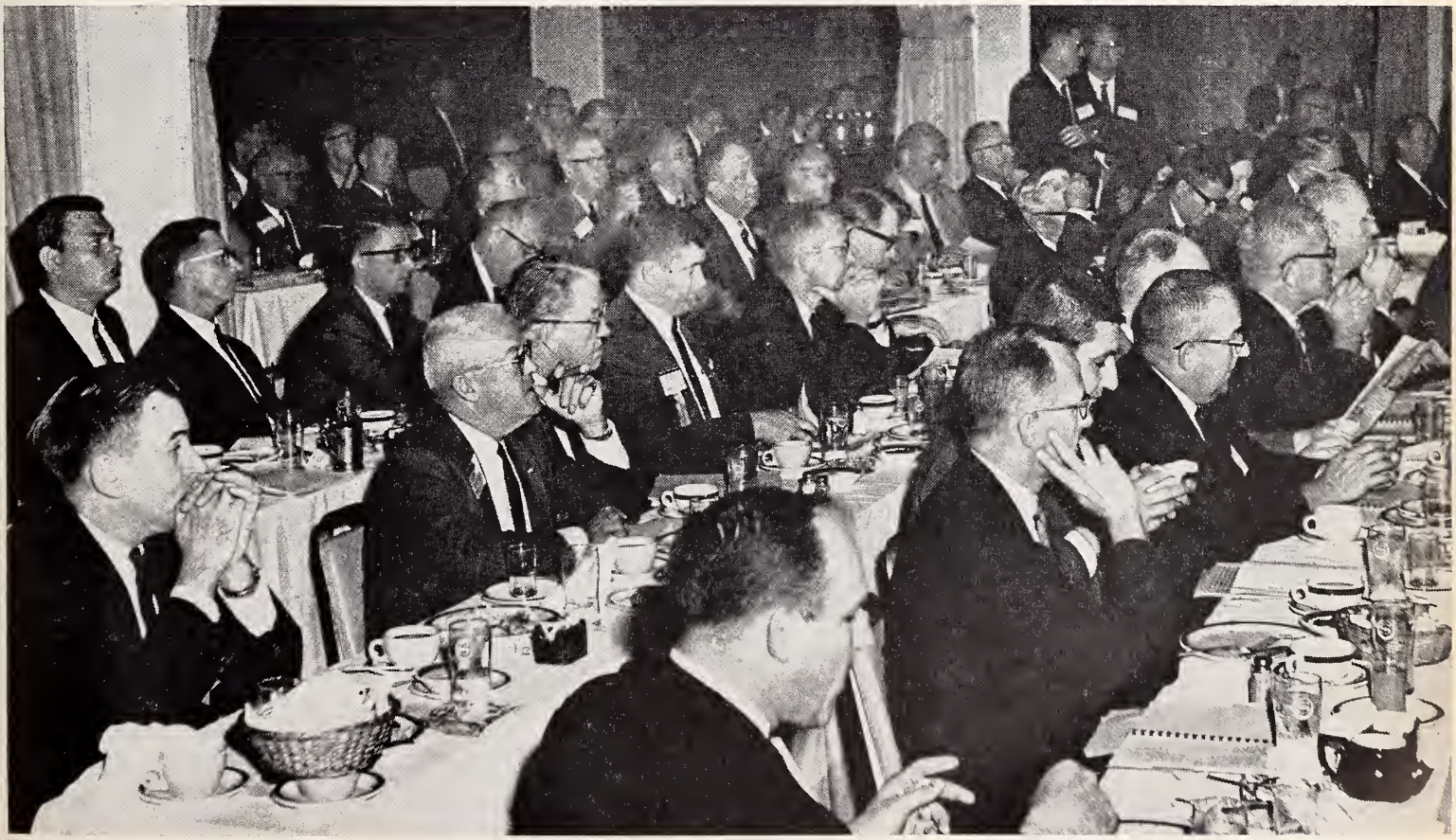
WALTER B. LOWE, publisher of the Greensburg Daily News, was awarded a public relations award for his paper's campaign for mass polio immunization in Decatur County.

DR. LESTER D. BIBLER, Indianapolis, and his wife presented Dr. E. S. Rifner, incoming ISMA president, with a medallion symbolic of his new office. The medallion will be passed on to each succeeding president of ISMA.

NEW LEADER—Dr. Neumann presents the presidential gavel to Dr. Eugene S. Rifner.

DR. RIFNER then presented Dr. Neumann with his presidential plaque.

SPEAKER of the evening was Dr. Milford O. Rouse, president-elect of the American Medical Association. Giving the Fifty-Year Club response at the annual dinner was Dr. E. S. Jones, Hammond.



THE FINAL MEETING of the House of Delegates was held Thursday morning in the West Dining Room.

DR. G. O. LARSON, LaPorte, addressed the House immediately after he was named president-elect of the ISMA.

DELEGATES to the American Medical Association gathered together for a picture at the close of the House of Delegates on Thursday.

Massive, worldwide clinical experience

Weight gain as infrequent as weight loss

New freedom from undesirable effects

New low cost

Contraindications—Mammary or genital carcinoma should be ruled out prior to administering Ovulen. Undiagnosed vaginal bleeding is also a contraindication to Ovulen use. A history of thrombophlebitis or pulmonary embolism, or both, is a contraindication to the use of Ovulen, unless its use is judged by the physician to be necessary despite the possible risk. Ovulen should not be used in women with suspected or overt liver dysfunction or disease. Ovulen is contraindicated in pregnant and nursing women and in patients with a history of cerebrovascular accident.

Warnings—Medication should be discontinued pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. Medication should be withdrawn if examination reveals papilledema or retinovascular lesions. Since the safety of Ovulen therapy in pregnancy has not yet been established, it is recommended that, in a patient who has missed two consecutive menstrual periods, pregnancy be ruled out before oral contraceptive therapy is continued.

Precautions—Because Ovulen may aggravate a tendency toward fluid retention in some patients, it should be administered cautiously to patients with a history of renal or cardiovascular disease (including hypertension), asthma, epilepsy or migraine. Any possible influence of long-term Ovulen therapy on pituitary, adrenal cortical, ovarian, hepatic or uterine functions requires further study. Oral contraceptives also should be administered cautiously to diabetic patients since a decrease in glucose tolerance has been observed in some patients taking these drugs. Patients on Ovulen may occasionally show abnormal glucose tolerance tests, but this does not necessarily indicate the presence of diabetes. Significant increases in platelet count, prothrombin and proconvertin tests, plasma thrombotic activity and plasma proteolytic activity have been reported.

Since estrogens may affect results of serum protein bound iodine and other thyroid function tests, these tests should not be considered definitive until Ovulen therapy has been discontinued for at least sixty days. Adrenal steroid serum levels and excretion may be affected by estrogens; the Metopirone® (SU-4885) test of pituitary-adrenal function may also be depressed. Abnormalities in hepatic function tests have also been reported, including some interference with dye excretion by the liver. This interference may give rise to Bromsulphalein® retention and jaundice in susceptible individuals. Serious liver dysfunction should be ruled out before continuing Ovulen administration when abnormalities in liver function tests occur.

Patients with a history of psychic depression should be observed carefully during treatment with oral contraceptives, and such treatment should be discontinued if depression recurs to a serious degree. Pre-existing fibroids may increase in size during Ovulen therapy. Such fibroids may regress to pretreatment size after Ovulen is stopped. In the event of breakthrough bleeding the possibility of nonfunctional causes should be borne in mind. Additional means of contraception should be used during the first seven days of Ovulen administration in the first treated cycle, because early ovulation may possibly occur.

Side Actions—The following adverse reactions have been reported with Ovulen; however, a causal relationship to Ovulen administration has not been established in all of the listed complaints: headache, dizziness, depression, breast complaints, amenorrhea, chloasma, vomiting, allergy, edema, migraine, pulmonary embolism, thrombophlebitis, visual difficulties, nervousness, rash, itching, decrease in libido, tiredness, malaise, hair loss and hair growth. A small incidence of nausea, spotting and breakthrough bleeding has been reported; these complaints tend to diminish markedly or disappear after the first cycle of treatment. Some of these side actions have required discontinuance of the drug.

Dosage—One tablet daily for 20 consecutive days beginning 5 days after the onset of menstruation.

Before prescribing see Detailed Product Information, Ovulen.

An extensive list of references on Ovulen is included in the literature mailed to physicians.

Research in the Service of Medicine
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Ovulen®

1 mg. Each tablet contains:
ethynodiol diacetate 1 mg.
mestranol 0.1 mg.

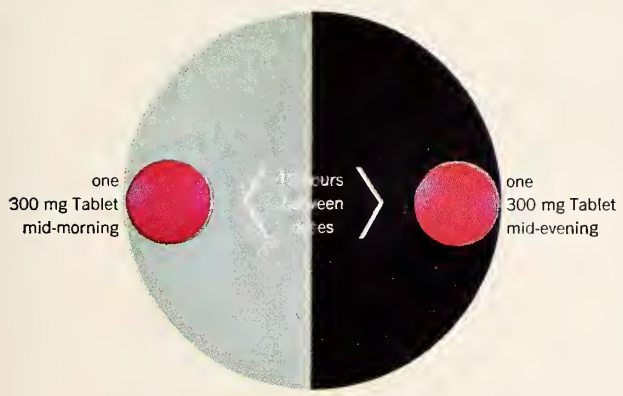
There is no more effective contraceptive available

why wonder about a drug

when you know

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE

is effective b.i.d.



It's made for b.i.d.

Effective in a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill—when the offending organisms are tetracycline-sensitive.

Contraindication—History of hypersensitivity to demethylchlortetracycline.

Warning—In renal impairment, usual doses may lead to excessive systemic accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort.

Precautions and Side Effects—Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. Use of demethylchlortetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect occurs mostly during long-term use but has also been observed in short treatment courses. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment. Side reactions include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and dermatitis. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Anaphylactoid reactions have been reported.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products.

Capsules: 150 mg; *Tablets:* film coated, 300 mg, 150 mg, and 75 mg of demethylchlortetracycline HCl.

LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

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Everyone says she's a barrel of fun

But what does she think?

Many overweight patients can benefit from the appetite control provided by the sustained anorexigenic-tranquilizing action of BAMADEX SEQUELS: anorexigenic action of amphetamine; tranquilizing action of meprobamate; prolonged action through sustained release of active ingredients.

Bamadex® Sequels®

DEXTRO-AMPHETAMINE SULFATE (15 mg.) WITH MEPROBAMATE (300 mg.) SUSTAINED RELEASE CAPSULES

to help establish a new dietary pattern

Contraindications: Dextro-amphetamine sulfate: in hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.

Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness.

Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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Pearl River, New York

695-6

President's Address

KENNETH O. NEUMANN, M.D.
Lafayette

AS one concludes a year as president of an organization, its members have come to expect a report of his stewardship. A politician would give a report of the "state of the union." A candidate "points with pride" or "views with alarm." However, one who has completed all these has a little more liberty, and I hope I can be a little more objective than the candidate or politician. I have chosen to make a few remarks on "principle versus pocketbook."

In the area of scientific medicine, our profession can point with pride to many accomplishments in the past few years. We were well prepared for the scientific and population explosion but not prepared for the socio-economic explosion. Our efforts in the socio-economic field and within our own organizations leaves much to be desired. I do not view with alarm the immediate future because you have already selected capable leadership and your headquarters staff is most efficient. The "state of our association's membership" causes me concern in our present politico-socio-economic conflicts.

About one year ago I concluded my remarks to the House of Delegates by quoting the remarks of Winston Churchill after Munich. He said, "And do not suppose this is the end! This is *only* the *beginning* of reckoning. This is only the *first* sip, the *first* foretaste of a bitter cup that will be offered to us year after year, unless we take our stand for freedom."

At that time the House of Delegates did take a stand on several important points:

1. opposing any dictation or coercion against the physician in determining the extent of his service, or the financial arrangement under which he provided service under Public Law 89-97;

2. that the charges of a "hospital based specialist" should *not* be merged with hospital charges, but should be established, billed and collected as other physician's fees;

3. that any carrier selected as an intermediary should be chosen on the basis that it abide by the principle of "usual and customary fee";

4. recommended that physicians bill and collect from *all* patients directly;

5. stated that history shows that the individual freedom of physicians can be maintained *only* by unity.

At that time I warned that hospitals, intermediaries and government agencies would try to place "the cat on our back" for every problem that would develop with Medicare, many of which we had pointed out repeatedly before the law was passed.

Since last year we have truly had blood, sweat, toil and tears, to no avail. As is their right, there have been those among us who have joined with the opposition and have collaborated with them in the mistaken belief that this will help solve our problems—surely, history has taught us a better lesson than this.

Desertion of Troops

Others have abandoned direct billing and taken assignment. Some have continued to merge their professional charges with hospital charges. What started out as "*principles*" *before* July 1, 1966, has suddenly turned into "*pocketbook*" after July 1, 1966. This action has placed your officers and association in a peculiar position of having to support resolutions of the House of Delegates while many known defections exist. I should like to ask of you, what your officers and association can accomplish if some of the troops desert, either for temporary financial gain or prestige? The more the desertions, the weaker the forces. Our opposition knows this and counts on our weakness for their success.

This house establishes policy for this association. If that policy does not coincide with your ideas or your county society's ideas, it is your privilege to attempt to convince the majority that the policy is incorrect. However, until you do this, the principles established remain policies of the Indiana State Medical Association. Perhaps this house needs to objectively review some of these policies at this session to provide the unity necessary.

Many of the plans we had projected for this year had to be deferred or abandoned because of the more pressing socio-economic problems imposed upon us. For this I must apologize, but first things must come first. The Future Planning Committee has been organized as directed by the last House of Delegates and is now functioning.

Our staff has done a tremendous job this past year and to them you owe a deep debt of gratitude. The chores piled upon them are monumental, and their response is magnificent. I can tell you that your staff is the envy of many other medical organizations. Our members owe much to the members on our commissions and committees. They have performed most effectively this year. On behalf of the association, as well as myself, Thank You! The Executive Committee and Council spend many hours each month working for you. Their devotion and self-sacrifice should inspire all of us to give more time to the ISMA.

The year has been exciting and challenging. At the same time it has been

depressing and discouraging. Seemingly, each day brought a new problem or a new crisis. I, and the other officers and the staff, spent many hours and days trying to find the answers. How could we best meet the needs of medicine within the policies established by this House of Delegates? We did the very best we could. We fully realized that we would be criticized from both sides and I am well aware that we did not please all of you.

Vacillating Policies

It is interesting to make note of the contrasts between the government attitude before and after July 1, 1966. Their pleading for cooperation and for medical help in formulating "plans and policies" via Task Forces before July 1, 1966, abruptly changed and were replaced by rules and regulations, often not in accord with the law. Many of these regulations demean the profession, attempt to divide and fragment the profession, and even contemplated punative action against those who do not abide by certain regulations. Their vacillating policies and attitudes make it even more difficult to arrive at a solution to our problem. In spite of our loud protests since then the ears and eyes of Washington remain closed, even until today.

Unfortunately, similar contrast appeared in our own organization and this is the basis of my theme, "Principles before July 1, and pocketbook after July 1." Many of our members apparently have accepted the invitation of Vice-President Humphrey on the front page of one of the "unofficial journals" in which he said, "Doctors, let us be partners."

Most have refused assignment because *they know* that the *refusal* to take an assignment means they still have *some* freedom from government control. Let us remember "freedom is *never* free." The hospitals or physicians who believe they can have their cake and eat it too have a rude awakening coming in the near future.

Presidential Recommendations

Throughout the year I have made suggestions to many of the committees and commissions. I shall not burden you with the myriad details, but should like to call only a few to your attention.

1. In visiting other state medical societies I found that commissions and committees report directly to the Council, thus keeping this body more up to date and relieving the House of Delegates of routing reports. I recommend such a procedure in Indiana.

2. I recommend that the House of Delegates approve each special section having an elected delegate in the House of Delegates with full privileges, in order that we may be better united.

3. The district meetings should be revised so that more time is allowed for ISMA officers and staff to brief the district members. Perhaps the ISMA should select the dates so the many conflicts in date we have had can be eliminated. Suggestions have been made that the ISMA should prepare a format and take it to each meeting. This type of program should be informative to all members — especially if time for "questions and answers" can be provided. I believe it would increase attendance and stimulate interest in district meetings.

4. We are in dire need of additional help in the field staff to bring closer relations between ISMA and its component societies. This is especially true with a legislative year in the immediate future.

More than 400 members of the association have taken the opportunity to call or write me during this past year. I have tried to answer each of you. This is a tremendous and arduous job, but provides another means of communication. *Many* of our members took me to task severely, but *a few* agreed with me. The abuse far outnumbered the commendation. Many times I could not give them the answer they wanted, but if you will recall, I said one year ago that any opinions I expressed would be, to the best of my knowledge, based on previous policy established by the House of Delegates. There are undoubtedly honest disagreements, but we must not let these disagreements fragment our profession.

I would remind you again that if you disagree with the policies now in effect this is the time to change them.

Since I am concluding about 15 years of activity in organized medicine, it gives me a chance to reflect a moment. Organized medicine, until the past few years, has done a good job in socio-economic areas; unfortunately, some of its activities were "delaying tactics." It did what it could and found it was not enough to satisfy a "new society." The time is now at hand, November 8th to be exact — when, if medicine is to have a chance to remain free, each individual physician must act. "I-HOPE" is one way to help, for those who wonder how.

"Blinded" to the Facts

Our public image is shattered in spite of the many advances "free medicine" has made in past years. Our profession has the image of a profession too divided and too timid to know its own mind, and blind to the facts that history tells us. Collaboration, weakness, and indecision cannot help our cause.

If we are going to default on our obligations and "let George do it", remember that George is the insurance company, the hospital association, the government agency and the social planners—none of whom are interested in us—except to use us, because we are a minority.

Being in attendance during the eclamptic gestation, the prolonged delivery, and treacherous neonatal course of Medicare, it is no wonder we are dismayed, frustrated, and bitter.

We hear those who would control us speak differently as the occasion demands. Before July 1, 1966, we had appeals for cooperation, wooing of the profession by HEW, the "Advisory Task Forces", etc. The government agency was speaking in terms of (1) quality medical care, (2) usual and customary fees, (3) "freedom" to

continue customary procedures. When July first came, the mask was removed. Government began complaining of increasing costs, impugning motives of hospitals and physicians alike, and in general beginning to put "the cat on our back."

The government seems to think medical costs should not rise. I have looked at my costs and strangely enough I find them up. Comparing 1966 charges with 1955 charges for service rendered *to me*, I find many have increased 30 to 50%. I have not heard of much government action in that direction. Many service calls to my home cost me much more than my house calls. If we must pay more taxes, including more taxes for "our Social Security", should not we be permitted to raise our fees? Guidelines seem to be out for everyone but hospitals and physicians, but health care costs rise just as other costs rise. I have not heard of any government action to lower *their* expenditures and our taxes.

"Controlled" Medical Practice?

We have had many problems in the last year and many challenges lie ahead. We are only beginning to feel the full force of attacks on medicine. Their objective seems to be substitute government coercion for private practice. It is apparent the strategy is to destroy the image of medicine, thus causing the entire system to fall. There is no doubt but that a concerted effort is to be made to destroy the free, private practice of medicine and replace it with a controlled medical practice.

How can we best face the challenge? How do we face up to our responsibilities for patient care and medical progress in a changing world and changing society?

1. First by uniting our efforts. The fragmentation of medicine must be reversed. Each man, each specialty can no longer go it alone and disregard the other's problem. Our theme might well be. "Physicians of Indiana—Unite."

2. A cold, dispassionate analysis of our position and policies must be made. This *must* be a decision of the House of Delegates and needs to be done now. *If* we need to make changes, let us do it NOW.

3. Medical education, both undergraduate and postgraduate, needs more study and support by ISMA. We certainly are more knowledgeable of the needs of our communities than are the educators and administrators who are far removed from them—especially those in Washington or Chicago.

4. The long sought agreement that Blue Shield will pay charges by hospital-based physicians that are billed independently can now be realized. This has been a long sought goal, yet many of these men tell me they *now* do not wish to change. What should our position be?

5. Do we need to make exceptions in direct billing for incompetent individuals, or for welfare recipients, to name a few. Which is paramount—"Principle or pocketbook" — "Some freedom or outright control?" You must decide — and now.

6. I and other ISMA officers and councilors have been bombarded by complaints about the "Doctor's Plan." Should we divorce ourselves from hospital and medical pre-payment plans or should we assert a stronger, more positive role in directing these plans. I strongly recommend the latter.

You must make these decisions. Once you make these critical decisions, your elected officers and staff will do their best to implement your desires. Don't condemn, ridicule, or abuse your officers and staff when they are carrying out *your* policies. Support them! ◀

Convention Election Results:

Dr. G. O. Larson is Named President-Elect

Dr. G. O. Larson, LaPorte general practitioner, was elected president-elect of the Indiana State Medical Association at the closing session of the House of Delegates in October.

Graduated from the Northwestern University School of Medicine in 1928, Dr. Larson has served organized medicine in Indiana in nearly every possible capacity for the last 30 years. He has served as president of the LaPorte County Medical Society, the 13th District Medical Society, the staff of Holy Family and Community Hospitals in LaPorte, the LaPorte School Board, the Indiana State School Board Association, the LaPorte Library Board and the LaPorte Kiwanis Club.

Dr. Larson was ISMA alternate councilor for six years, councilor for several years, a member and chairman of many ISMA committees and commissions, ISMA delegate for many years, on the board of directors of Indiana Blue Shield for 11 years and is serving his third term on the executive committee of ISMA.

Also taking office during the convention were Drs. Ottis N. Olvey, Indianapolis, re-elected treasurer; Lester H. Hoyt, Indianapolis, re-elected assistant treasurer and Lowell H. Steen, Whiting, elected chairman of the Council. Dr. Ralph V. Everly, Indianapolis, was re-elected chairman of the Executive Committee. Dr. Burton E. Kintner, Elkhart, was named to replace Dr. Larson on the Executive Committee.

Dr. Harold C. Ochsner, Indianapolis, was re-elected to the post of delegate to the American Medical Association for a two year term beginning January, 1967, and Drs. Eugene Senseny, Fort Wayne and Frank H. Green, Rushville, were named delegates to replace Drs. E. S. Jones, Hammond, currently vice-president of the AMA, and Francis L. Land, Fort Wayne, who has accepted a federal medical post in Washington, D.C.

Their alternate delegates are Drs. James H. Gosman, Indianapolis, Robert M. Brown, Marion and K. O. Neumann, Lafayette, immediate past-president of ISMA. Other delegates who will represent the ISMA and whose terms will expire in December, 1967, are Drs. Guy A. Owsley, Hartford City and Jack E. Shields, Brownstown. Their alternates are Drs. Maurice E. Glock, Fort Wayne and Dwight W. Schuster, Indianapolis.

Taking over their official duties as new councilors for their districts at the convention were Drs. Joe E. Dukes, Dugger, Second District and Dr. Wilbert McIntosh, Riley, Fifth District. Drs. Donald R. Taylor, Muncie, Eighth District Councilor and Lowell J. Hillis, Eleventh District Councilor, re-elected to their posts as councilors, also resumed duties.

Alternates who will represent their districts until 1967 are Drs. A. W. Cavins, Terre Haute, Fifth District; Paul Sparks, Winchester, Eighth District and George B. Gattman, Elkhart, Thirteenth District. Alternates selected to serve until 1969 were Drs. Frank Green, Rushville, Sixth District; John O. Butler, Indianapolis, Seventh District; Herman Wing, Gary, Tenth District and James A. Harshman, Kokomo, Eleventh District.

Results of the various section elections are as follows:

Section on Surgery: Chairman—Joseph C. Finneran, Indianapolis; Vice-chairman—Donald M. Schlegel, Indianapolis; Secretary—Henry Larzelere, Marion.

Section on Internal Medicine: Chairman—I. E. Michael, Indianapolis; Vice-chairman—Louis Sandock, South Bend; Secretary—Robert L. Rudesill, Indianapolis.

Section on Ophthalmology and Otolaryngology: Chairman—Lewis E. Morrison, Indianapolis; Vice-chairman—M. Richard Harding, Indianapolis; Secretary—George A. Clark, Indianapolis.

Section on Anesthesiology: Chairman—Eugene Schmidt, Fort Wayne; Vice-chairman—William M. Matthews, Indianapolis; Secretary—Jerry R. Miller, Indianapolis.

Section on General Practice: Chairman—Ross Egger, Middletown; Vice-chairman—Jay S. Reese, Martinsville; Secretary—Robert Mouser, Indianapolis.

Section on Obstetrics and Gynecology: Chairman—Joseph F. Thompson, Indianapolis; Vice-chairman—Robert M. Reid, Columbus; Secretary—Tom W. Wachob, Jr., Kokomo.

Section on Public Health and Preventive Medicine: Chairman—Donald M. Kerr, Bedford; Vice-chairman—T. Neal Petry, Delphi; Secretary—Henry G. Nester, Indianapolis.

Section on Radiology: Chairman—Louis C. Bixler, Bloomington; Vice-chairman—Richard A. Silver, Indianapolis; Secretary—William A. Anshutz, Indianapolis.

Section on Nervous and Mental Diseases: Chairman—Donald F. Moore, Indianapolis; Vice-chairman—Hans Meyer, Westville; Secretary—Gene F. Lynn, Indianapolis.

Section on Pathology: Chairman—Joseph L. Haymond, Indianapolis; Vice-chairman—Robert J. Frost, Michigan City; Secretary—Robert L. Costin, Indianapolis.

Section on Pediatrics: Chairman—Roland E. Miller, Lafayette; Vice-chairman—Wendell E. Brown, Indianapolis; Secretary—Morris Green, Indianapolis.

THE WINNERS—117th Annual Convention French Lick, Oct. 10-13, 1966

ART AND HOBBY SHOW

Oil Painting:
First: Paul Hart, M.D., Evansville
Second: Charles P. Schneider, M.D., Evansville
Third: Dr. Schneider, Evansville

Honorable Mention:
Paul Hart, M.D., Evansville
Ray H. Burnikel, M.D., Evansville
C. X. McCalla, M.D., Paoli
Gene Ress, M.D., Tell City
T. T. Suzuki, M.D., Covington

Watercolor Painting:
First: W. L. Harlan, M.D., Evansville
Second: Dr. Burnikel, Evansville
Third: Dr. Harlan, Evansville

Drawing:
Dr. Harlan, Evansville

Photograph — Black and White:
Walter Dycus, M.D., Evansville

Photograph — Color:
Dr. Dycus, Evansville

Sculpture:
First: Dr. Harlan, Evansville
Second: Dr. Harlan, Evansville
Third: Dr. Harlan, Evansville

Collection or Hobby:
First: Dr. McCalla, Paoli
Second: Robert Arendell, M.D., Evansville

Special Exhibit:
Maurice V. Kahler, M.D., Indianapolis

SCIENTIFIC EXHIBIT AWARD WINNERS

Award No. 1 — Harley P. Palmer, M.D., Department of Pathology, Methodist Hospital, Indianapolis — SERUM ENZYME PATTERNS AS DIAGNOSTIC AIDS

(Dr. Palmer also was awarded the Aesculapean certificate and cash award of $200.00, donated by Mead Johnson Laboratories)

Award No. 2 — W. P. Loh, M.D., pathologist, Gary, Indiana — ABNORMALITY OF WHITE BLOOD CELLS IN MENTAL ILLNESS

Award No. 3 — Robert A. Garrett, M.D., John P. Donohue, M.D., Thomas A. Arnold, M.D., Indiana University Medical Center, Indianapolis — METASTATIC WILMS' TUMOR THERAPY WITH SURVIVAL

MEN'S GOLF TOURNAMENT

Championship

1st	Burkhardt	74 gross
2nd	Gossard	79 gross

Low Net

1st	Wood	72 net
2nd	Connelly	72 net
3rd	Beck	72 net
4th	Henry	74 net
5th	Balsbaugh	74 net
6th	Kurtz	74 net
7th	McClure	74 net
8th	Dannacher	74 net

WOMEN'S GOLF TOURNAMENT

18-hole winners:
1st place.....Mrs. Margaret (W. A.) Nelson, Gary
2nd place.....Mrs. Toni (Richard J.) Laker, Ft. Wayne
3rd place.....Mrs. Mary (Tom W.) Johnson, Indianapolis
4th place.....Mrs. Roberta (John) Deever, Indianapolis
5th place.....Mrs. Betty (William) Lybrook, Indianapolis
6th place.....Mrs. Helen (Richard) Connelly, Ft. Wayne
7th place.....Mrs. Jan (John C.) Richter, La Porte
8th place.....Mrs. Marilyn (William) Dye, Oakland City
9th place.....Mrs. Judy (Jacob E.) Pruitt, Gary
10th place.....Mrs. Marion (Ray H.) Burnikel, Evansville
11th place.....Mrs. Mary (Leonard W.) Neal, Munster

9-hole winners:
1st place.....Mrs. Margaret (John B.) Beaven, Jasper
2nd place.....Mrs. Dorothy (Sam) Bechtold, South Bend

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House of Delegates Proceedings

FRENCH LICK SESSION

October 10-13, 1966

The House of Delegates convened at 2:00 p.m., Monday, October 10, 1966, in the North Convention Hall of the French Lick-Sheraton Hotel, French Lick. Dr. Eugene S. Rifner, president-elect, called the first meeting to order and presided until Dr. Kenneth O. Neumann, the president, delivered his presidential address. Dr. Neumann and Dr. Rifner presided at the final meeting of the House on October 13.

Credentials Committee Reports

On motion of many, duly seconded, attendance slips signed by the delegates were accepted in lieu of a roll call at the first meeting. Dr. Guy B. Ingwell, chairman of the Credentials Committee, reported 100 delegates, six past presidents, 12 councilors, one alternate councilor, the president, the president-elect, the treasurer, the assistant treasurer, two delegates to the AMA, one AMA trustee and 25 guests present at this meeting.

At the second meeting it was moved by Dr. B. E. Kintner, seconded by many, put to vote, and carried, that attendance slips filled in by the delegates would constitute the roll call. Present for this meeting, as recorded on signed attendance slips, were 106 delegates, six past presidents, 11 councilors, three alternate councilors, the president, the president-elect, the treasurer, the assistant treasurer, two delegates to the AMA, one AMA trustee, the editor of *The Journal* and 18 guests.

According to Chapter IV, Section 3, of the Bylaws, 50 delegates constitute a quorum. The House of Delegates, therefore, was declared open and ready for the transaction of business.

The chairman made the following announcements:

1. The Bylaws may be amended at any annual convention by a majority vote of all the delegates present at that convention, after the amendment has laid on the table for one day. (Chapter XXXII, Section 1, Bylaws).

2. The House of Delegates may amend any article of the Constitution by a two-thirds vote of the delegates present at any annual convention, provided that such amendment shall have been presented in open meeting at the previous annual convention and that it shall have been published twice during the year in *The Journal* of this association. (Article XIV, Constitution.)

3. The meetings of this House of Delegates will operate on Robert's Rules of Order.

4. On any question that is before the House, any member of the House has a right to call for a division of the House.

In Memoriam

The House stood in tribute to those members of the association who had served as members of the House of Delegates, or in an official capacity in the association, who had passed away since the last meeting of the House in October, 1965:

CHARLES BENEDICT, LaGrange. President, LaGrange County Medical Society, 1957 and 1959, and secretary, 1951, 1952, and 1955.

THOMAS E. CARNEAL, Winamac. President, Pulaski County Medical Society, 1956-58, and secretary, 1924-55.

JOSEPH CLARK, Huntington. President, Huntington County Medical Society, 1965.

MARION E. CLARK, Cambridge City. Member, Committee on Indiana Inter-Professional Health Council, 1953.

CHARLES C. CRAMPTON, Delphi. Delegate, Carroll County, 1935, 1937, 1939, 1950; member, 1937-38, and chairman, 1939-40, Committee on Veterans' Affairs; member, M-Day and Veterans' Affairs Committee, 1941-42.

PAUL K. CULLEN, Indianapolis. Member, Committee on Cancer, 1957.

LLOYD H. DAVIS, Shoreham, Vermont (formerly Crawfordsville). Secretary, Montgomery County Medical Society, 1926-27.

MYERS B. DEEMS, Evansville. Member, Committee on Convention Arrangements, 1957.

GEORGE B. DeTAR, Moore Haven, Florida (formerly Winslow). Delegate, Pike County, 1946.

ARNOLD H. DUEMLING, Fort Wayne. Secretary, 1940, vice-chairman, 1941, and chairman, 1942 and 1947, Section on Surgery; member, Committee for the Study of Lay Activity in Medical Practice, 1946; delegate, Allen County, 1946-48.

DAVID DUKES, Tell City. Delegate, Perry County, 1935; secretary, 1942, 1946-51, and president, 1954, Perry County Medical Society; member, Committee on Inter-Professional Health Council, 1953.

RAY ELLEDGE, Hammond. Delegate, Lake County, 1947-61 and 1963; member, Committee on Rehabilitation Services, 1945 and 1947; Medical Advisory Committee for Vocational Rehabilitation, 1946; chairman, Committee on Constitution and Bylaws, 1950; member, Committee on Civil Defense, 1950-52; Committee on Diabetes, 1953; Anti-National Health Insurance, 1954; Committee on Civil Defense, 1956-57 and Commission on Medical Economics and Insurance, 1958.

RUSSELL B. ENGLE, Winchester. Delegate, Randolph County, 1935-36; secretary, Randolph County Medical Society, 1944.

PAUL W. FERRY, Kokomo. Secretary, Howard County Medical Society, 1926-27; member, Committee on Postwar Medical Service, 1945-46.

DALLAS FICKAS, Evansville. Member, Committee on Occupational Diseases, 1938; Veterans' Affairs Committee, 1946; Committee on Scientific Exhibits, 1953, and Commission on Medical Education and Licensure, 1960-62; delegate, Vanderburgh County, 1956-58.

ROBERT L. FULLERTON, Monticello (formerly Tipton). Secretary, Tipton County Medical Society, 1933-34.

HENRY W. GANTE, Anderson. Secretary, Madison County Medical Society, 1921.

FRANK M. HALL, Indianapolis. Member, Committee on Crippled Children Services, 1954, and Committee on Maternal and Child Health and Crippled Children Services, 1955; secretary, Commission on Aging, 1962, and member, 1963-65.

GILBERT T. HYATT, Evansville. Member, Committee on Crippled Children Services, 1949.

LOWELL R. JOHNSON, Lafayette. President, Tippecanoe County Medical Society, 1959.

JAMES L. LAMEY, Anderson. Secretary, Madison County Medical Society, 1948-50, and president, 1964; member, Committee on Medical and Nursing School Scholarships, 1951-52; Veterans' Affairs and Rehabilitation Committee, 1953, and Committee on Crippled Children Rehabilitation, 1956.

ISAAC H. LAWSON, Kendallville. President, Noble County Medical Society, 1955.

DONALD C. McCLELLAND, Lafayette. AMA alternate delegate, 1928-29; member, Committee on Prevention of Traffic Accidents, 1939-40; Committee on Control of Cancer, 1941-43; Committee on Cancer, 1948-49.

CLARENCE H. MEAD, Bluffton. Secretary, Wells County Medical Society, 1925-26.

JUSTIN R. NASH, Albion. Delegate, Noble County, 1946, 1948-56; president, Noble County Medical Society, 1958 and 1965; member, Committee on Prepayment of Medical and Surgical Care, 1945; Committee on Scientific Work, 1950; Committee on Chronic Illness, 1953, 1956-57.

RICHARD M. POTTER, Ridgeville. Secretary, 1952-54, and president, 1955, Randolph County Medical Society; delegate, Randolph County, 1952 and 1954.

MICHAEL SHELLHOUSE, Gary. Delegate, Lake County, 1949, 1953, 1957, 1961-65; president, Lake County Medical Society, 1958; member, Commission on Convention Arrangements, 1958-61 and 1963.

OSCAR A. TURNER, Madison. Secretary, Jefferson County Medical Society, 1917-1951; member, Committee on Secretaries' Conference, 1944-45; Medical Economics Committee, 1945-46; councilor, Fourth District, January to May 19, 1948.

JAMES L. WALKER, LaFontaine. Delegate, Wabash County, 1937-38.

CHARLES E. WHIPPS, Carlisle. Secretary, Sullivan County Medical Society, 1917-19.

FRED M. WHISLER, Wabash. Secretary, Wabash County Medical Society, 1915-16, 1939-41, 1949; delegate, Wabash County, 1949; member, Committee on Industrial Health, 1945-47, 1950; Committee on Crippled Children Services, 1948.

CHESTER S. WHITE, Rosedale. Member, Committee on Special Medical Defense Fund, 1933; delegate, Parke-Vermillion County Medical Society, 1936, 1942.

PAUL E. WILSON, Boonville. Secretary, Warrick County Medical Society, 1919.

1965 Minutes

On motion duly made, seconded by many, minutes of the meetings held at Indianapolis on October 11 and 14, 1965, were approved as printed in the December, 1965, *Journal*.

1966 Reference Committees

The chairman announced the appointment of reference committees for the 1966 session as follows:

SECTIONS AND SECTION WORK:

William A. Karsell, Indianapolis (Marion), *Chairman*
Noel Graves, Vevay, (Jefferson-Switzerland)
John C. Glackman, Jr., Rockport (Spencer)
Edward D. Miller, Fort Wayne (Allen)
James A. Harshman, Kokomo (Howard)

RULES AND ORDER OF BUSINESS:

Clarence G. Kern, Lebanon (Boone), *Chairman*
Charles M. Sinn, Evansville (Vanderburgh)
Donald L. McKinney, Otterbein (Benton)
Joseph L. Haymond, Indianapolis (Marion)
Paul W. Sparks, Winchester (Randolph)

MEDICAL EDUCATION AND HOSPITALS:

Maurice E. Glock, Fort Wayne (Allen), *Chairman*
Raymond E. Nelson, South Bend (St. Joseph)
Thomas M. Brown, Muncie (Delaware-Blackford)
John D. Wilson, Evansville (Vanderburgh)
Glenn W. Irwin, Jr., Indianapolis (Marion)

LEGISLATION:

Herbert O. Chattin, Vincennes (Knox), *Chairman*
Warren M. McClure, Kokomo (Howard)
Thomas D. Armstrong, Michigan City (LaPorte)
Ray H. Burnikel, Evansville (Vanderburgh)
Wallace R. Van Den Bosch, Lafayette (Tippecanoe)

PUBLIC RELATIONS:

Lowell Painter, Winchester (Randolph), *Chairman*
Betty Dukes, Dugger (Sullivan)
Richard R. Eggers, Crawfordsville (Montgomery)
S. E. Bechtold, South Bend (St. Joseph)
David Hadley, Indianapolis (Marion)

HYGIENE AND PUBLIC HEALTH:

W. Lloyd Bridges, Fort Wayne (Allen), *Chairman*
John O. Butler, Indianapolis (Marion)
Glen Ward Lee, Richmond (Wayne-Union)
Ramon B. DuBois, Lafayette (Tippecanoe)
L. John Vogel, Mt. Vernon (Posey)

AMENDMENTS TO CONSTITUTION AND BYLAWS:

Leslie M. Baker, Aurora (Dearborn-Ohio), *Chairman*
Morris E. Thomas, Indianapolis (Marion)
V. J. Santare, Munster (Lake)
A. E. Stouder, Kempton (Tipton)
W. Robert Orr, Mishawaka (St. Joseph)

REPORTS OF OFFICERS:

Harry R. Baxter, Seymour (Jackson-Jennings), *Chairman*
Forrest J. Babb, Stockwell (Tippecanoe)
Philip E. Yunker, Howe (LaGrange)
Tom S. Shields, Richmond (Wayne-Union)
Joseph F. Ferrara, Franklin (Johnson)

CREDENTIALS:

Guy B. Ingwell, Knox (Starke), *Chairman*
Irvin H. Sonne, New Albany (Floyd)
T. N. Petry, Delphi (Carroll)
C. O. Almquist, Gary (Lake)
Thomas J. Conway, Terre Haute (Vigo)

INSURANCE:

Malcolm O. Scamahorn, Pittsboro (Hendricks), *Chairman*
Burton E. Kintner, Elkhart (Elkhart)
J. S. Farquhar, Fort Wayne (Allen)
Charles E. Test, Indianapolis (Marion)
William G. Bannon, Terre Haute (Vigo)

MISCELLANEOUS BUSINESS:

Philip J. Rosenbloom, Gary (Lake) *Chairman*
Max Hoffman, Covington (Fountain-Warren)
Fred Smith, Jr., Tell City (Perry)
Bill Freeland, Batesville (Ripley)
Louis F. Sandock, South Bend (St. Joseph)

Amendments to the Constitution

By roll call vote, the House adopted the following amendments to the Constitution (see roll call vote, page 1547). (Words or sections added are italicized).

1. Deletion of paragraph 3, Article IX, Sec. 5, which reads as follows: "The alternate Councilor shall not have the power of discussion if the regularly elected Councilor is present."
2. **Article V. — House of Delegates.** After the word "Delegates" and before the word, "elected," add the following: "*or their designated alternates*," and after the word "Councilors," add "*or their designated alternates*", making this paragraph read:
   Article V. — House of Delegates. The House of Delegates shall be the legislative and business body of the Association and shall consist of (1) Delegates, *or their designated alternates*, elected by the component county societies; (2) the Councilors, *or their designated alternates*, and (3) the ex-presidents of the Indiana State Medical Association. . . ."
3. Add to Article VI, after the word "Councilors" in the first line, the words, "*with power to vote, and their duly elected alternates, each of the latter without power to vote, except in the absence of his Councilor*," making this paragraph read:
   Article VI. — Council. The Council shall consist of (1) the Councilors, *with power to vote, and their duly elected alternates, each of the latter without power to vote, except in the absence of his Councilor*, and (2) *ex-officio*, the President, President-elect, Treasurer with power to vote and Assistant Treasurer without power to vote except in case the Treasurer be absent. . . .

Reading of Communications

The chairman read the following memorandum, dated September 26, 1966, from the Indiana State Board of Health.

MEMORANDUM

There is an agreement between all of the State Registrars and the National Center for Health Statistics, that all Vital Record

forms will be reviewed for content every ten (10) years.

Sometime in the early part of 1967, every physician will be furnished a sample copy of the new birth, death, and stillbirth certificates. If there is any item of medical or statistical importance that you would like to see added to these records contact the State Board of Health, Division of Vital Records.

Resolutions from the Floor

The chairman announced that resolutions Nos. 19 through 32, received too late for publication in the Handbook, had been distributed to the delegates and had been reviewed by Dr. Kern's Committee on Rules and Order of Business. "In accordance with Chapter IV, Section 7, of the Bylaws, the House may consider resolutions introduced at this time upon a two-thirds vote of the House of Delegates."

The chair asked that these resolutions be accepted en masse for reference to the proper committees.

The motion that these resolutions be accepted was duly made, seconded by many, put to vote and adopted on a hand vote.

The chairman read these resolutions by number, title, and the "Resolve."

Reports of Reference Committees

REPORTS OF OFFICERS

The following matters were referred to the Reference Committee on Reports of Officers. All reports will be found on the pages indicated in the September, 1966, Vol. 59, *Journal of the Indiana State Medical Association* with the exceptions herein listed. The president's address will be found on pages 1516-18 of the December, 1966, *Journal*. The addresses of the president-elect the president of the Woman's Auxiliary, and the report of the Future Planning Committee are printed herewith.

President's address
President-elect's address
Executive Secretary (page 1053)
Treasurer (pages 1053-54)
Chairman of Council (pages 1054-55)
Councilors' reports (pages 1055-57)
Journal Editor (page 1057)
Delegates to AMA (pages 1057-60)
Address of President of Woman's Auxiliary
Executive Committee (pages 1061-62)
Report of Future Planning Committee

President's Address

The address of the president, Dr. Kenneth O. Neumann, is printed on pages 1516-18 of the December, 1966, *Journal of the Indiana State Medical Association.*

President-elect's Address

DR. EUGENE S. RIFNER, president-elect, addressed the House as follows:

Where do we go from here? Which path do we take? Since the passage of medicare we look right, but go left. We agree that direct billing is our proper course, but we take assignments. This House of Delegates has stated that x-ray and pathology must be separated from hospital domination, but more than half have not done so. Those who have, have on many occasions not had the support of their fellow physicians and have lost their positions without any hue or cry from their colleagues.

Where do we go from here? What is the price to pay for freedom? For what do we fight? Where do we draw the line? Can we be practical — accepting intervention, and still be free? Where do we go from here? This is the baffling problem of a president-elect as he sees his inauguration but a few days away.

The real answers to these momentous questions lie with you, the House of Delegates of the Indiana State Medical Association. Many say we fight a lost cause. Many say we abandon the fight. Which way is right? In the next few days you must decide. Based on your decisions your president of 1966-67 will act, will work, will travel, will take abuse and perhaps will take praise.

But he would be amiss if he did not state how it looks to him. I see those who value personal gain and today's dollar biting large chunks from the pedestal which holds our image. I would cast these people away as chafe be trodden under the feet of free men. Freedom is not gained by a soft road. Freedom is not gained by lack of sacrifice. Freedom is not gained by cowardice. Freedom is not gained without danger. Freedom is not gained by a lack of unity. Neither can freedom be kept under these circumstances.

We must preserve the freedoms of American medicine, the greatest, most envied, medical care in the world. We must preserve these by hard work, by strengthening such weaknesses as are present before big government does it for us.

We must care for the patient regardless of race, creed, color, welfare, medicare, or any other false divisions that may be placed in our path. We must seek better, and better and better ways to provide this care to every citizen in this great state of Indiana without the shackles of bureaucratic dictatorship. We must strengthen Blue Shield by making it aware of the needs of organized medicine, and aware of the policies of this House of Delegates, and by making ourselves aware of the needs of Blue Shield.

On our political side, we must improve I-HOPE. I-HOPE needs new life; I-HOPE needs new vigor; I-HOPE needs new purpose; I-HOPE needs new money; I-HOPE needs new will; I-HOPE needs your renewed enthusiastic support.

We must strengthen the Indiana medical association by being loyal members, loyal to the policies of this House of Delegates, and spreading through your leadership and my leadership this loyalty to every member in Indiana. We must strengthen the educational and academic factors of medicine in this state through the improvement on or acceptance of the Indiana plan, and, or new medical schools or any other means that may be possible. We must make Indiana attractive to others by the sacrifice of time to internships and residencies in those localities now able to support them, and by improving those already in existence.

We must look to our weaknesses and convert them, and correct them — not look in another direction and ignore them until some outsider finds them, corrects them, or covers their correction with manipulation by unscientific and unproven theoretical misjudgments. If we look for our weaknesses and instead of making them stumbling blocks, use them as stepping stones to improve patient care and improvement of our service to our fellow men, we will do far more than all advertising could do to improve our image. In other words, we must be heads up, we must be hep, too, and in the groove with today's path of progress. We must use every facet of the computer, good business judgment, modern political methodology, and all other assets available to us to improve patient care.

We must be strong. We must be resolute. We must be devoted. We must care. We must be our brother's keeper of freedom. We must be our brother's anchor in the storm of need. We must stand under the banner of the Indiana State Medical Association as one medical unit, cohesive in purpose, adherent in principle, and glued with the love for the truth. Over the ramparts of this unit with good faith, you and I shall move forward improving the health, and caring for the sick, wounded and afflicted of all Indiana in such a manner as to say unto them — "Come unto us all ye who are weak and heavy laden and we will give you strength."

I would ask each and every delegate to search his endeavors for his profession in the light of the foregoing. The road of today is rough. The road of tomorrow appears quite jagged. The burden upon my shoulders is heavy. I ask you for constructive criticism, for help not to lighten the burden, but perhaps to make it a bit more tolerable, and at times to give me a guiding hand as we trod a path of storm.

I feel that if all of us put our shoulders to the task, we can through the ingenuity so manifested by our Hoosier forefathers find a way to give the best patient care to all

citizens of Indiana and still stay, as best we can, within the confines of the free enterprise system.

This is the challenge. This is the task.

REFERENCE COMMITTEE ACTION

Dr. Forrest J. Babb, member of the reference committee, presented the following report, in the absence of Dr. Harry R. Baxter, chairman:

Your reference committee reviewed the addresses of the president and president-elect, and the committee commends these officers for their fine presentations. Your committee also recommends that this House approve implementation of the four recommendations made by our president in his remarks.

Mr. Chairman, I move the adoption of this section of our report.

(Motion seconded, put to vote, and carried.)

Woman's Auxiliary Presidential Address

MRS. A. B. SCALES, Huntingburg, president of the Woman's Auxiliary to the Indiana State Medical Association, addressed the House as follows:

Dr. Neumann, distinguished guests and members of the House of Delegates: As Indiana's Sesquicentennial Year draws to a close, many people have been reminded of its long and distinguished history. Native Hoosiers have been made more proud of their heritage. A major role in this period has been played by members of the medical profession. During the last 38 years your auxiliary has endeavored to contribute to this progress. Time has come to report the year just ending.

We are indebted to you, Dr. Neumann, Dr. Everly, Mr. Waggener and your very helpful staff for all the guidance and assistance you have given. Our fiscal year closed in April with a total membership of 2,878, a gain of 63 over the previous year. We are operating this year on a budget of $7,276.00, an increase of $144.00 over last year's budget. A very successful and informative House of Delegates, held in Fort Wayne in April, brought the year to a close. Mrs. Dunstone's report to National in June covered one-half of the year since your last meeting.

Gifts to AMA-ERF (American Medical Association Education and Research Foundation) totaled $17,650.80, an increase of $2,993.83 or 20.42% over the preceding year. Of this amount $15,289.75 was earmarked for medical schools, while $2,361.05 went for the Loan Guarantee Fund. Through arrangement with the banks, every dollar given permits a loan of $12.50. The per capita gift was $6.13 and won for us, for the second consecutive year, the state plaque for the highest per capita amount in our membership category. And I should add, the Vanderburgh Southwestern received the county plaque — a certificate it was, for the highest per capita in the county of their membership category. That's in the nation.

As I reported to you in the August issue of your *Journal*, the check presented to the AMA in June, representing the total gift from the doctors' wives of 50 states, was $345,593.81, the largest amount ever given in one year and an eight percent increase over 1965. This year AMA is asking us for $500,000.00. The addition of the Biomedical Research Institute to the formerly two-fold program of "funds for medical schools" and "funds for loans to students, interns and residents" necessitates increased effort. Since 1951, over two million dollars has been contributed by the national auxiliary to the AMA-ERF, while more than three millions have been raised for nursing and other health career scholarships and loans.

Indiana's reported scholarships for the past year are in excess of $19,000. These are given on varying bases to prospective nurses, medical technicians and those interested in other paramedical fields. Material on Health Careers has been distributed to junior and senior high schools. Indiana Health Careers, Inc., at the request of guidance counselors, has supplied some very excellent charts and graphs to encourage well-trained personnel in the ancillary health areas.

School children collected over four thousand pairs of glasses for International Health; bandages and Johnny-coats were made by members and their church groups; medical equipment, instruments, drugs and journals were shipped to World Relief. In one instance a large shipment of woolen yarn, for mittens and sweaters, was donated and shipped to Korea.

Gifts for patients and volunteer workers in mental hospitals are increasing annually. One auxiliary entertained patients at a special program in their Woman's Club; another financed daily newspapers, while a third supplied a canteen fund for patients with no pocket money. This active participation in mental health organizations accounts for many hours of volunteer work. Emphasis is being put on suicide prevention and means of educating against alcoholism. In increasing numbers, volunteers have supported teaching the illiterate and retarded. One auxiliary has been actively involved in support of an institution for emotionally disturbed children—in another area, improvement of race relations was inaugurated. Hospital volunteer work, community service boards, Red Cross blood banks—volunteer hours are thus tabulated in the thousands.

Goals accomplished in the legislative field may be classified under the headings of a membership well informed on legislative matters; promotion of Political Action courses; training in public speaking; and an effective communication system between county chairmen and the state chairman. A well-planned and very stimulating Political Action Seminar was conducted at the ISMA Building in March. I-HOPE and AMPAC are frequently brought to the attention of members by communications and personal appearances of our two liaisons.

The Indiana Chapter of the Woman's Auxiliary to the Student American Medical Association (WA-SAMA) is carrying on a most worthwhile and stimulating program. The dean of the Indiana medical school addressed them; an attorney discussed the subject of malpractice suits and a panel of four wives of physicians in varied specialties answered pertinent questions. Our state liaison is working very effectively in interpreting aims. A new project this fall is the creation of a "loan closet." Articles of every sort needed by a family are being collected, then loaned to the families of medical students for a small charge.

Rural Health activities include: Encouraging young doctors to locate in rural communities; urging better health through immunization; promoting 4H activities; working with rural-urban agencies; farm accident prevention; cooperation with Red Cross and police departments; encouraging water safety and many other community-supported programs for the betterment of rural life.

In support of the ISMA's program for public education in Medical Self-Help through television, the auxiliary is planning to ask each county organization to arouse public interest and encourage viewing.

Our *Hoosier Doctor's Wife* continues to be published four times a year and is a most valuable channel of communication. This, plus *M.D.'s Wife*, published by the the national auxiliary, provide every member with a complete picture of aims and accomplishments, both on the state and national level.

The annual workshop, to be conducted during this convention, promises to bring together a good representation from county auxiliaries for a briefing in the suggested plans given by national officers and chairmen at the North Central Regional Workshop, held in Chicago last week. In my report, prepared for the November issue of your *Journal*, you will find a resume of the Chicago conference and workshop and an outline of the emphasis for the year, namely — Health of Children and Youth of School Age on the one hand and Direct Service Projects for the Homebound and Elderly on the other. Each county auxiliary is asked to determine the phase of program material most fitting and most needed in its own community and gear its activities in cooperation with other community groups.

We are proud to assist you in your endeavors for better medical care and are proud of our record in so doing.

Report of Eleventh Councilor District

The annual meeting of the Eleventh Councilor District was held on September 21, 1966, at the Holiday Inn in Kokomo, Indiana. Sixty-seven members, out of a total possible number of 219, were present.

The secretary's report was read and approved without correction. The treasurer's report was also given, and audited by a committee appointed by Dr. Ferrara. The auditing committee was composed of Drs. Herd, Brown and Rendel.

The necrologist's report, given by Dr. Gatzimos, included the names of a number of fellow physicians of the Eleventh District who have died in the past two years. A few moments of respectful and reverent silence gave evidence of our regret.

Mr. James A. Waggener, Executive Secretary of the state medical society, gave a very informative talk in regard to Title XIX and other elements of Medicare. Welfare payments were discussed and it was emphasized that at present, if at all possible, accepting payment under the present circumstances should be deferred until the situation is finally resolved. It was also emphasized that a great deal of work is being done toward solving the other problems of Medicare particularly the item of medical necessity for admission to a hospital. Further information will be given to physicians by way of the Newsletter as soon as it is obtained. Mr. Waggener did urge that resolutions which are presented at the meeting in French Lick next month should be resolutions that we can live with, as many vital decisions will be made at that time.

Mr. Herbert P. Dixon, Physician Relations Director of Blue Shield, also discussed some elements of Medicare, particularly the way in which the Blue Shield office arrives at the "reasonable and customary fee."

Several physicians from the Bunker Hill Air Force Base were introduced to the group by Dr. Ferrara, President of the Eleventh Councilor District.

Dr. Warren McClure of Kokomo urged that those who desire should give generously to "I-HOPE" in support of their candidates.

Dr. Robert H. Maschmeyer of Logansport, on behalf of the Cass County Medical Society, invited the Eleventh District physicians to Logansport for their annual meeting on the third Wednesday in September, 1967.

Dr. Lester L. Renbarger of Grant County then opened the discussion as to the need for authorizing the necessity for admission for a Medicare or Blue Cross patient, since the admission notes and progress notes clearly meet such a need.

After much discussion, Dr. Camille Parker of Logansport made the following motion: "I move that the requirement for certification and recertification as to the necessity for hospitalization is redundant and objectionable. Admission diagnosis and proper progress notes are adequate." This motion was seconded by Dr. Hillis. Dr. Ernest Murray then moved to table the motion, but this was defeated. Dr. Parker's motion was then passed unanimously.

Dr. E. S. Rifner, president-elect of the association, briefly discussed the problems ahead of the state medical association, and asked the help of all those present in the coming year as it holds the promise of being a stormy one.

Dr. Brown then discussed the Marion County resolution on reshuffling of districts, and wished to emphasize that representation as a whole in Marion County is extremely poor in comparison with that of other counties, such as our own, and he urged the group as a whole to speak strongly against such reshuffling.

Election of officers resulted in the following: councilor, Dr. Lowell J. Hillis of Logansport; alternate councilor, Dr. James A. Harshman of Kokomo; president, Dr. Joseph Bean of Logansport; secretary-treasurer, Dr. Fred Poehler of LaFountain; necrologist, Dr. Gatzimos of Logansport.

The scientific program was presented by two physicians from the Cleveland Clinic. Dr. Robert E. Hermann spoke on the topic of surgical therapy of thyroid disease, and Dr. Penn G. Skillern spoke on the diagnosis and treatment of hyperthyroidism and hypothyroidism. Both papers were excellent, and were well received.

A social hour followed, with the members present as guests of the Howard County Medical Society. A delicious buffet dinner was then enjoyed by 114 physicians and their wives. Dr. Garvey Bowers of Kokomo presented slides and a narrative summary of his trip through Russia which were made most enjoyable by his sprinkling of dry wit throughout.

LOWELL J. HILLIS, M.D., *Councilor*

REFERENCE COMMITTEE ACTION

Dr. Forrest J. Babb continued with the report of the Reference Committee on Reports of Officers:

The report of the Woman's Auxiliary was excellent, and this committee commends the auxiliary for its continuing support and activity in behalf of medical practice.

All reports which were printed in *The Journal* were reviewed and adopted as printed.

Mr. Chairman, I move acceptance of this section of this report.

(Motion seconded, put to vote, and carried.)

Report of Future Planning Committee

The Future Planning Committee of the Indiana State Medical Association met twice during the year, on June 12 and on September 18 in the headquarters office of the association.

At the first session of this committee, Dr. Kenneth O. Neumann, president of the association, appeared before the group and cited 15 areas of investigation to be considered in future planning for the Indiana State Medical Association.

At the second meeting of the committee, the agenda consisted of three items: (1) the role of the ISMA in formulating health care legislation; (2) consideration of special efforts to bring specialty groups into closer integration with the ISMA with the specific question involving the possibility of these groups having a delegate or delegates to the ISMA, and (3) selection of AMA delegates.

At the September 18 meeting where these three items were discussed initially, the committee generally reflected the opinion that in all future legislation the ISMA's approach should be one of a positive nature, especially as reflected in the initiation of new health care legislation and the support of good legislation from other sources. It was generally felt that opposition and negative attitudes by the state medical association, in the past, which was many times displayed in waiting for health legislation to be introduced by others, was extremely detrimental to the public image and destructive to the natural role of the association as a leader in all matters pertaining to health.

In reference to the attitude of a more progressive, positive approach to matters of health legislation in the state of Indiana, the committee discussed, at great length, the matter of hospital facilities and health care services in the state's penal system, specifically citing the undesirable situation in the Michigan City State Prison. The LaPorte County Medical Society has worked closely with the warden of that prison and it is their feeling, and the feeling of Warden Lane, that the time is presently very appropriate for the establishment of a medical director in the State Department of Correction to exercise authority over all state prison hospital and medical operations and appointments of medical staffs. The Future Planning Committee endorses this proposal and recommends that the Commission on Legislation be encouraged to study this issue and support it to the utmost during the forthcoming session.

The Future Planning Committee further decided that its role should be one of continual encouragement to the active commissions of the ISMA and cited specifically, the excellent activites of the Commission on Legislation and the Commission on Medical Education and Licensure, especially as the

activities of these two commissions have been reflected in revisions and broader interpretation of the Medical Practice Act.

The committee wishes to go on record with the following motion, which was adopted unanimously by the committee. It was moved by the committee that approval and support be given to the following principles involved in medical education in Indiana: (1) that the committee support the Indiana Plan for Medical Education and favors its immediate implementation, (2) that the Future Planning Committee supports the ultimate establishment of a new medical school with emphasis on utilization by this school of a similar plan of education, and (3) with the support of these two principles, both the present medical education needs and the future long-range needs, in supplying sufficient physicians for the state of Indiana can be met.

Discussing the problem of bringing specialty groups into closer integration with the Indiana State Medical Association, it is the committee's recommendation that the specialty groups of the ISMA be permitted to designate delegates to the House of Delegates of the association in the interest of, not only strengthening the specific sections of the ISMA, but strengthening the structure of the House of Delegates. It was recommended that this matter be brought before the House of Delegates as a recommended change in the Constitution and Bylaws of the association and that either the House of Delegates take action in this area or that the Commission on Constitution and Bylaws, during the forthcoming months, make definite efforts to implement this suggestion by study and recommended changes in the association's Constitution and Bylaws.

In consideration of the third item, the selection of delegates to the American Medical Association, the committee did not take any action since it was the opinion that such action was political in nature and that upon review of the previous selections of delegates by the House of Delegates of the ISMA, that, at all times, in the past, excellent men have been elected to these extremely important positions and have served with effective enthusiasm and devotion to Indiana medicine.

EARL MERICLE, M.D., *Chairman*
M. E. GLOCK, M.D.
JOHN FITZPATRICK, M.D.
A. W. RATCLIFFE, M.D.
FRED CARTER, M.D.
WILLIAM CHALLMAN, M.D.
JAMES WENGER, M.D.
CHARLES GILLESPIE, M.D.
LESLIE BAKER, M.D.

REFERENCE COMMITTEE ACTION

Dr. Forrest J. Babb continued with the report of the Reference Committee on Reports of Officers:

The report of the Future Planning Committee was also adopted as distributed to the members of the House of Delegates.

Mr. Chairman, I move adoption of this portion of the report.

(Motion seconded, put to vote, and carried.)

There was no report from the Indiana Chapter of the Student AMA.

Mr. Chairman, I move adoption of this report as a whole.

(Motion seconded, put to vote, and carried.)

SECTIONS AND SECTION WORK

No report.

RULES AND ORDER OF BUSINESS

Dr. Clarence G. Kern, chairman, presented the following report, which he said he hoped would be considered a critical report and that each of the delegates would accept it as such and make every effort to try to do better in the future:

Your Reference Committee on Rules and Order of Business met at 1:00 p.m., October 10, 1966. Those present were Dr. Sinn, Dr. Haymond and myself.

Additional resolutions from Marion, Vanderburgh, Madison and Shelby counties which had not been printed in the Handbook were considered and approved for presentation to the House of Delegates, after it was ascertained that each was accompanied by a written letter of urgency and 150 copies of the resolution.

Additional resolutions were also introduced by the Council. These are not required by the Bylaws to have approval of the Reference Committee on Rules and Order of Business.

This made a total of 15 last-minute or emergency resolutions which were not printed in the Handbook and did not have the will and pleasure of the members of the Indiana State Medical Association who were unable to attend the annual convention.

I would urge, as Dr. Lowell Painter did last year when he was chairman of this reference committee, that resolutions be presented early, at least 45 days before the annual meeting, as required by the Bylaws, so as to better inform all the members of ISMA what you as delegates are voting on.

Respectfully presented by the Reference Committee on Rules and Order of Business, Dr. Kern, chairman, Dr. Sinn, Dr. McKinney, and Dr. Haymond.

(Dr. Kintner's motion for adoption of the report was seconded by many, discussed by Dr. Gosman, put to vote, and carried.)

MEDICAL EDUCATION AND HOSPITALS

The following matters were referred to the Reference Committee on Medical Education and Hospitals. All reports will be found on the pages indicated in the September, 1966, Vol. 59, *Journal of the Indiana State Medical Association*, with the exception of the report of the State Board of Medical Registration and Examination, which is printed below. Resolutions introduced before the House and referred to this committee are printed herewith.

Commission on Medical Education and Licensure (pages 1071-72)

State Board of Medical Registration and Examination report

Resolution No. 9—COMMENDATION OF PROPOSED CURRICULUM STUDY AND EXPANSION, I. U. SCHOOL OF MEDICINE

Resolution No. 15—INDIANA PROPOSAL FOR FUTURE MEDICAL EDUCATION IN INDIANA

Resolution No. 18—COMMENDATION OF I. U. SCHOOL OF MEDICINE PLAN FOR EXTENSION OF MEDICAL EDUCATION

Resolution No. 19—EXPLORATION OF WAYS TO ATTRACT ADDITIONAL PRACTICING PHYSICIANS TO INDIANA AND OF PERSUADING THOSE WHO TRAIN HERE TO REMAIN HERE

Resolution No. 20—GRADUATE MEDICAL CENTERS

Resolution No. 21—EXPANSION OF MEDICAL EDUCATIONAL FACILITIES

Resolution No. 29—MEDICAL EDUCATION IN INDIANA

Resolution No. 31—HOSPITAL EMERGENCY DEPARTMENT OPERATION

REFERENCE COMMITTEE ACTION

Dr. Maurice E. Glock, chairman, presented the following report:

Your Reference Committee on Medical Education and Hospitals met at 9:00 a.m., October 11, 1966, in Parlor C of the Convention Hall. All members of the reference committee were present. A goodly number of members were present and all matters were thoroughly discussed. Matters referred to the committee were:

(1) *The Report of Commission on Medical Education and Licensure* (Pages 114 and 115, Handbook); (2) *Report of State Board of Medical Registration and Examination* (Presented at first meeting of House of Delegates); (3) Resolution No. 9—COMMENDATION OF PROPOSED CURRICULUM STUDY AND EXPANSION, I. U. SCHOOL OF MEDICINE (Pages 75 and 76, Handbook); (4) Resolution No. 15—INDIANA PROPOSAL FOR FUTURE

MEDICAL EDUCATION IN INDIANA (Pages 77 and 78, Handbook); (5) Resolution No. 18 — COMMENDATION OF I. U. SCHOOL OF MEDICINE PLAN FOR EXTENSION OF MEDICAL EDUCATION; (6) Resolution No. 19 — MARION COUNTY ON EXPLORATION OF WAYS TO RETAIN PHYSICIANS; (7) Resolution No. 20 — GRADUATE MEDICAL CENTERS; (8) Resolution No. 21 — EXPANSION OF MEDICAL EDUCATION FACILITIES; (9) Resolution No. 29 — MEDICAL EDUCATION IN INDIANA; (10) Resolution No. 31—HOSPITAL EMERGENCY DEPARTMENT OPERATION.

Medical Education

The first item of business was the Report of the Commission on Medical Education. The commission is to be complimented for helping sponsor the renewed Preceptor Program and is urged to continue full support for this program. We also urge that the commission continue full cooperation in the implementation of the Indiana University Plan, in strengthening programs of postgraduate medical education, and increasing the number of medical graduates available in Indiana and mechanisms to insure greater numbers of practicing physicians in the state of Indiana. We recommend that joint meetings with the State Board of Registration and Examination be held as needed to effect satisfactory liaison. We commend the commission for their activities in the past year.

REPORT OF BOARD OF MEDICAL REGISTRATION AND EXAMINATION IN INDIANA

Number of medical candidates who took the examination*	304
Number of medical candidates who failed the examination*	41
Number of medical candidates who failed in one subject only*	2
Number of medical candidates from foreign medical schools who took the examination	154
Number of medical candidates from foreign medical schools who failed the examination	38
Number of candidates who took the special chiropractic examination	0
Number of candidates who failed the special chiropractic examination	0
Number of candidates who took the regular chiropractic examination	0
Number of candidates who failed the regular chiropractic examination	0
Number of candidates who took the physical therapy examination	5
Number of candidates who failed the physical therapy examination	0
Number of medical applicants granted license in Indiana by endorsement/reciprocity	106
Number of osteopathic applicants granted license in Indiana by endorsement/reciprocity	15
Number of medical applicants who were endorsed to other states	317
Number of osteopathic applicants who were endorsed to other states	0
Number of applicants granted physical therapy license in Indiana** by endorsement/reciprocity	37
Number of applicants granted chiropractic license in Indiana*** by endorsement/reciprocity	17
Number of citations during the year (all physicians)	3
Number of revocations during the year (all physicians)	1
Number of physicians who voluntarily surrendered their Narcotic Stamps to the Internal Revenue Dept., Post Office	6

* Includes foreign graduates.

** Physical therapists by endorsement (10/1/65 to 10/1/66)

*** Chiropractors by endorsement (10/1/65 to 10/1/66)

R. A. Snapp, M.D., Secretary, Board of Medical Registration and Examination of Indiana.

REFERENCE COMMITTEE ACTION

Dr. Maurice E. Glock, chairman, presented the following report:

The Report of the State Board of Medical Registration and Examination was received. We would appreciate further information in regard to the number of applicants who are granted license in Indiana by endorsement or reciprocity (106), the number of medical applicants who were endorsed to other states (317) and the number of applicants granted chiropractic license in Indiana by endorsement or reciprocity (17).

(Dr. Glock commented here that it would be helpful if a member of the State Board of Medical Registration would accompany this report to the state meeting and discuss the various items of the report for the information of the Reference Committee and the membership.)

Mr. Chairman, we recommend the adoption of this section of this report.

(Motion seconded by many, put to vote, and carried.)

Resolution No. 9

Introduced by: GRANT COUNTY MEDICAL SOCIETY

Subject: COMMENDATION OF PROPOSED CURRICULUM STUDY AND EXPANSION, I. U. SCHOOL OF MEDICINE

WHEREAS, the medical profession has the obligation to the public to provide competent and sufficient medical care, and

WHEREAS, due to many reasons in the United States there now exists an increasing deficit in the availability to the public of practicing physicians, and

WHEREAS, in the state of Indiana there has been a failure to maintain this ratio of physicians to the patients in comparison with neighboring states as well as in many others in spite of the increased number of medical students graduating from the one medical school in Indiana, and

WHEREAS, competent physicians in all categories of endeavor, both specialists and particularly general practitioners, should be encouraged by all proper means to remain or to come to Indiana, and

WHEREAS, a number of proposals have been placed before a committee of the state legislature hopefully to deal with these problems, and

WHEREAS, the proposal presented by the dean and faculty of Indiana University Medical School is being considered as one means of accomplishing these objectives, the following advantages of this proposal are noted.

1. It would utilize existing institutions, facilities and physicians over the entire state, thus potentially involving all interested physicians in the teaching and training of doctors, thereby appropriately stimulating and improving the existing professional endeavor in the broadest possible manner.
2. By its proposed utilization of modern communications techniques and devices, savings in money can be anticipated in accomplishing a prompt increase in medical training in the state.
3. By its imagination and pioneering concept, the state of Indiana already has received national and international academic and public recognition so that the implementation of such a program would place Indiana in the forefront of the rapidly evolving field of medical education, thereby attracting both students and faculty of quality from the widest sources.
4. By improving and altering the scope of the undergraduate medical curriculum and by increasing the graduate medical training potential for the state, physicians schooled in Indiana as well as others may be attracted to come to or remain in Indiana to serve its citizens.
5. While this proposal offers prompt potential for implementation with almost immediate results, it does not eliminate but rather encourages and could subsidize the ultimate development of additional medical schools in the state whenever and wherever this potential may be truly realized,

NOW THEREFORE BE IT RESOLVED,

that the Indiana University Medical School dean and faculty be commended for the far-sighted, revolutionary and stimulating curriculum study and expansion proposal they have laid before the state legislature as one means of accomplishing these objectives, and that the Indiana State Medical Association offer its services in supporting this and any other proper effort directed toward improving the quality and availability of medical care to the citizens of our state.

Resolution No. 15

Introduced by: FORT WAYNE (ALLEN COUNTY) MEDICAL SOCIETY

Subject: INDIANA PROPOSAL FOR FUTURE MEDICAL EDUCATION IN INDIANA

WHEREAS, the need to retain Indiana educated physicians and attract out of state physicians is of immediate importance in order to provide adequate health care of the citizens of Indiana, and

WHEREAS, national surveys prove conclusively that physicians tend to remain in areas in which they receive their intern and residency training, and

WHEREAS, the Indiana Proposal for Future Medical Education in Indiana would provide a network of cooperative facilities on a statewide basis, as well as coordinated improvement and expansion of intern and residency programs with cooperating community hospitals, and

WHEREAS, the Indiana proposal would provide by 1969 an expanded program for interns and residents which will produce medical care for the citizens of Indiana, and

WHEREAS, this orderly expansion would provide significantly more physicians (under professional level guidance) for Indiana at a relatively modest cost, and

WHEREAS, confusion reigns as to the appropriate site for the proposed second medical school, and

WHEREAS, further study and consideration should be given before any final decision is made concerning the location of the proposed second medical school,

NOW THEREFORE BE IT RESOLVED, that the Indiana State Medical Association urge the state legislature to give full implementation to the Indiana University proposal and its effect properly evaluated before any final decision is given to the selection of a second medical school.

Resolution No. 18

Introduced by: RUSH COUNTY MEDICAL SOCIETY

Subject: COMMENDATION OF I. U. SCHOOL OF MEDICINE PLAN FOR EXTENSION OF MEDICAL EDUCATION

We wish to commend Indiana University School of Medicine for its plan to extend to all hospitals and all doctors in the state of Indiana the privilege of participating in a new concept of medical education for our undergraduate and graduate doctors of medicine.

The envisioned plan represents an all out effort to fill the gaps which are apparent to medical educators and practicing physicians. It will, in addition, help the state of Indiana to keep at home our own graduating intern and resident physicians by introducing them to our hospitals and medical men.

We like the idea of being asked to help in the way we might be of service to our state medical school.

THEREFORE, BE IT RESOLVED: We wish to commend I.U.S.M. for their attempt to improve medicine in Indiana.

Resolution No. 29

Introduced by: VANDERBURGH COUNTY MEDICAL SOCIETY

Subject: MEDICAL EDUCATION IN INDIANA

WHEREAS, the matter of extending and improving medical education in Indiana is of utmost concern to all citizens of this state, especially physicians, and

WHEREAS, the increasing population and expanding economy has made it necessary to maintain a proper ratio of practicing physicians to meet this need in Indiana, and

WHEREAS, an extension of presently available educational facilities and techniques could be progressively developed in the immediate future at relatively modest cost, which may attract students for training and keep graduates for practice in Indiana, and

WHEREAS, these facts were recognized by the Council and House of Delegates of the Indiana State Medical Association in a resolution approved at the annual meeting in 1965 stating "that Indiana State Medical Association urges the proper authorities of the state of Indiana to take appropriate steps as soon as possible to bring about the orderly expansion of opportunities for medical education through the establishment of additional geographically distributed medical schools,"

NOW THEREFORE BE IT RESOLVED, that the Vanderburgh County Medical Society endorses a program of continuing improvement and strengthening of the Indiana University Medical School and Medical Center, and

BE IT FURTHER RESOLVED, that Indiana University be encouraged to implement a regional hospital affiliated internship and residency educational program.

REFERENCE COMMITTEE ACTION

Dr. Maurice E. Glock, chairman, continued with the report of the Reference Committee on Medical Education and Hospitals:

Next considered were Resolutions 9, 15, 18 and 29 which were similar in scope. The Indiana Plan for State Wide Medical Education has been enthusiastically received by physicians over the entire state of Indiana and has received favorable notice by medical educators throughout the entire country. We recommend adoption of Resolution No. 9, with the deletion on page 76 of the Handbook, paragraph 5, line 4, the words *and could subsidize* and Resolution No. 18 and Resolution No. 15 with the exception of deletion of the last two lines in the last paragraph: "*and its effect properly evaluated before any final decision is given to the selection of a second medical school*" so that the resolution reads: "BE IT RESOLVED that the Indiana State Medical Association urge the state legislature to give full implementation to the Indiana University proposal."

We recommend that Resolution No. 29 be accepted with the insertion of the word "community" in the next to last line between "regional" and "hospital" so that this reads: BE IT FURTHER RESOLVED, that Indiana University be encouraged to implement a regional *community* hospital affiliated internship and residency educational program.

We recommend and move that Resolutions 9, 15, 18 and 29 as amended be adopted.

(Motion seconded by Dr. Popp, put to vote, and carried.)

Resolution No. 19

Introduced by: MARION COUNTY MEDICAL SOCIETY

Subject: EXPLORATION OF WAYS TO ATTRACT ADDITIONAL PRACTICING PHYSICIANS TO INDIANA AND OF PERSUADING THOSE WHO TRAIN HERE TO REMAIN HERE

WHEREAS, the public and the medical profession are well aware of the need for more practicing physicians in both rural and urban areas of Indiana, as the general population increases, and know that many physicians who receive their medical education here do not remain to practice in this state, and,

WHEREAS, proposed expansion of the existing school of medicine, or establishment of a second facility, to produce more doctors is but one facet of the search for a solution to the problem, and,

WHEREAS, decision as to which of the

above approaches to take in developing that particular facet is the prerogative of the Indiana General Assembly and not of the Indiana State Medical Association, and,

WHEREAS, exploration of ways of attracting physicians to Indiana and of retaining those physicians who have received their training here is appropriate and necessary and well within the purview of the medical profession in Indiana,

WHEREAS, a year-long self-study report of Indiana University states, in part, that "A nationwide survey shows that physicians have a marked tendency to locate their practices in the areas where they did their internships or residencies. The state of Indiana suffers badly as a result because the number of internships and residencies which are available is especially low."

NOW THEREFORE BE IT RESOLVED, that the Indiana State Medical Association conduct a comprehensive study to determine why many physicians who train here do not remain here, and,

BE IT FURTHER RESOLVED, that such study include a determination of how the Indiana State Medical Association can best participate in implementing a proposal of the Indiana University School of Medicine that additional approved internships and residencies be established in Indiana hospitals, and,

BE IT FURTHER RESOLVED, that the study include ways that the cost of the approved internships and residencies can be met without increases in hospitalization costs borne only by patients.

REFERENCE COMMITTEE ACTION

Dr. Maurice E. Glock, chairman, presented the following report:

Resolution No. 19 was next considered. This resolution calls for a study of why physicians who train in this state and do not remain here, how ISMA can best implement the proposal of the Indiana University School of Medicine in establishing additional approved residencies and internships, and a study of ways of meeting the costs of such residencies and internships without increasing hospitalization costs to patients. We heartily concur in this resolution and move its approval.

(Motion seconded by many, put to vote, and carried.)

Resolution No. 20

Introduced by: TIPPECANOE COUNTY MEDICAL SOCIETY

Subject: GRADUATE MEDICAL CENTERS

WHEREAS, Indiana attempts to establish programs to attract practicing physicians, and

WHEREAS, it has been shown nationally that physicians practice most often near the institution where graduate training was taken, and

WHEREAS, Indiana at present has a shortage of graduate educational programs, and

WHEREAS, present graduate medical centers are training doctors for the entire state of Indiana, it is appropriate that they receive some form of financial remuneration from public funds,

NOW THEREFORE BE IT RESOLVED, that Tippecanoe County Medical Association recommends to the Indiana legislature the formation of a graduate medical education commission. The commission should consist of two physicians in private practice of medicine and a representative of directors of medical education in Indiana, a representative of Indiana State Medical Association, a representative of Indiana University School of Medicine, a representative of Indiana State Board of Health and a representative of each house of the Indiana legislature. That this commission be concerned with the establishment of funds to be used for the encouragement and development of graduate medical centers at appropriate places throughout the state of Indiana. That this commission consider requests for grants from institutions with ongoing graduate programs and proposed graduate program and consider places to establish graduate medical centers.

REFERENCE COMMITTEE ACTION

Dr. Maurice E. Glock, chairman, presented the following report:

The next item of business was Resolution No. 20. It was the opinion of your reference committee that the intent of this resolution is laudable but that the structure of such state appointed commission needs much further study as to administrative and fiscal details and therefore we recommend that this resolution be referred to the Commission on Medical Education and Licensure for appropriate study. I so move, Mr. President.

(Motion seconded by many, put to vote, and carried.)

Resolution No. 21

Introduced by: DELAWARE-BLACKFORD COUNTY MEDICAL SOCIETY

Subject: EXPANSION OF MEDICAL EDUCATIONAL FACILITIES

WHEREAS, through resolution passed on October 14, 1965, the Indiana State Medical Association recognized Indiana's increased demand for health care services, and,

WHEREAS, the Indiana State Medical Association urged the proper authorities of the state of Indiana to take appropriate steps as soon as possible to bring about the orderly expansion of opportunities for medical education through the establishment of additional geographically distributed medical schools, and,

WHEREAS, the Indiana State Medical Association has recognized the need for further strengthening of the Indiana University School of Medicine, and,

WHEREAS, the Legislative Committee to Study Medical Education in Indiana, a bipartisan committee appointed by the Legislative Advisory Commission and including the two physician legislators, has now completed its study and has recommended (1) The further strengthening of the Indiana University School of Medicine and the implementation of the Indiana university proposal for strengthening internship and residency programs, (2) The establishment of a second school of medicine to be located on the campus of Ball State University and (3) The initial appropriation for organization and planning of the second medical school during the 1967-69 biennium.

NOW THEREFORE BE IT RESOLVED, that the Indiana State Medical Association urges the acceptance by the General Assembly of the recommendations of the Legislative Committee to Study Medical Education in Indiana.

REFERENCE COMMITTEE ACTION

Dr. Maurice E. Glock, chairman, presented the following report:

Resolution 21 was thoroughly presented by a member of the Delaware-Blackford County Medical Society delegation and was discussed pro and con by many of those present. We wish to commend this society for their enthusiasm and interest in this problem. We must reaffirm the action of the House of Delegates of ISMA of last year as referred to in the first three paragraphs of this resolution. We are in accord with this resolution with the exception of the words in Section 2 of the last whereas: "to be located on the campus of Ball State University" and the addition at the end of the resolution of the words "with the exception of any specific geographical location of a new medical school" and the change of the word in the resolve, in the next to last line from "*the*" to "*these*" so that the last paragraph would read: "NOW THEREFORE BE IT RESOLVED, that the Indiana State Medical Association urges the acceptance by the General Assembly of *these* recommendations of the Legislative Committee to Study Medical Education in Indiana, *with the exception of any specific geographical location of a new medical school.*" We recommend the acceptance of this resolution, as amended.

(Motion seconded by many, put to vote, and carried.)

Resolution No. 31

Introduced by: COUNCIL OF ISMA
Subject: RESOLUTION ON HOSPITAL EMERGENCY DEPARTMENT OPERATION

WHEREAS, all general hospitals in the state of Indiana are required by law to provide emergency care facilities, and since these are no longer used only to treat acute accident victims, the concept of an emergency *room* is giving way to the concept of an emergency *department*: and

WHEREAS, hospital emergency department visits have increased more than 170% in the past 10 years, and

1. The dramatic increase in emergency cases has not been matched with dynamic efforts for an upgrading of services.
2. There is no uniformity among communities for emergency medical care.
3. There is a lack of staff and facilities in many small hospitals.
4. The use of emergency facilities as an after hours physician's office finds people with non-emergencies in almost every emergency department.
5. Many insurance plans cover emergency department visits but do not cover office visits and house calls.

NOW THEREFORE BE IT RESOLVED, that this House of Delegates of the ISMA adopt the following statements of principle:

1. Physician staffing of an emergency department must be responsibility of the entire medical staff.
2. The emergency department physician staff must be under control of a committee of one or more members of the general medical staff.
3. Any physician, or group of physicians, covering an emergency department should be ethical. They should bill their patients rather than accept a salary from the hospital.
4. If any subsidy is necessary to get emergency department coverage it should come from the hospital administration medical staff or possibly from the county medical society.
5. Specialists who do not care to accept the responsibility for patient care outside his own field of interest, shall obtain appropriate coverage.
6. Physicians who arrange hours by appointment only, should make appropriate arrangements to be able to see emergency illness in his office.

REFERENCE COMMITTEE ACTION

Dr. Maurice E. Glock, chairman, presented the following report:

The final item on the agenda was Resolution No. 31. We concur that changes in medical practice have created many new problems in the operation of hospital emergency rooms, but feel that the problems are so diverse from one hospital to another, and from one community to another, that it is impossible with the time available to adequately study and implement the matters contained in this resolution. We recommend it be not adopted, but referred back to the Council for further study.

We move the adoption of this section of this report.

(Motion seconded by Dr. Popp, put to vote, and carried.)

Mr. President, I move the adoption of this report as a whole.

(Motion seconded by many, put to vote, and carried.)

I would like to take this opportunity to thank the many who aided in the formulation and study of these resolutions, and, in general, the fine support of the members of the committee who were: Raymond E. Nelson, Thomas M. Brown, John D. Wilson, and Glenn W. Irwin. Thank you very much.

LEGISLATION

The following matters were referred to the Reference Committee on Legislation. All reports will be found on the pages indicated in the September, 1966, Vol. 59, *Journal of the Indiana State Medical Association*. Resolutions introduced before the House and referred to this committee are printed herewith.

Commission on Legislation (page 1065)

Resolution No. 1—CHANGES IN MEDICAL LICENSURE ACT OF INDIANA

Resolution No. 3—TUBERCULIN TESTING OF PRE-SCHOOL CHILDREN

Resolution No. 7—COMMUNITY DUMPS

Resolution No. 10—MEDICAL DIRECTOR, DEPARTMENT OF CORRECTION

Resolution No. 13—RECOMMENDATIONS ON ISSUANCE OF DRIVERS' LICENSES

Resolution No. 14—LICENSING OF OPERATORS OF MOTORCYCLES

Resolution No. 25—STATE SUBSIDIES FOR FULL-TIME LOCAL HEALTH DEPARTMENTS

Resolution No. 32—IMPLEMENTATION OF TITLE XIX

REFERENCE COMMITTEE ACTION

Dr. Herbert O. Chattin, chairman, presented the following report:

The following matters were referred to the Reference Committee on Legislation:

1. *Report of Commission on Legislation.* The report of the Commission on Legislation was approved with the addition of the following statement to be added to the paragraph which is numbered 3: "*and that the legislature be requested to approve an adequate budget to implement this law.*"

Mr. Chairman, we move the adoption of this section of this report, as amended.

(Motion seconded by many, put to vote, and carried.)

Resolution No. 1

Introduced by: ST. JOSEPH COUNTY MEDICAL SOCIETY
Subject: CHANGES IN MEDICAL LICENSURE ACT OF INDIANA

WHEREAS, there has been for years, and still is, a shortage of interns in Indiana and, also, a shortage of general practitioners and certain specialists in some areas of the state and,

WHEREAS, the Medical Licensure Act restricts and discourages interns, residents and teaching fellows and general practitioners and specialists from coming to Indiana from other states which tends to reduce the quality and the proper number of physicians and educators,

NOW THEREFORE BE IT RESOLVED, that the St. Joseph County Medical Society requests that the Medical Education and Licensure Commission, along with the Legislative Commission of the Indiana State Medical Association study, propose, and vigorously support changes in the Medical Licensure Act at the meeting of the Indiana Legislative Assembly in 1967 to allow interns, residents, teaching fellows and qualified M.D.'s to more easily secure license in Indiana including the consideration of offering the necessary examination more than once a year, and to restudy the advisability of temporary licenses to qualified doctors of medicine.

REFERENCE COMMITTEE ACTION

Dr. Herbert O. Chattin, chairman, presented the following report:

2. *Resolution No.* 1—CHANGES IN MEDICAL LICENSURE ACT. This resolution was amended by the reference committee to read as follows: (changes italicized)

WHEREAS, there has been for years, and still is, a shortage of interns in Indiana and, also, a shortage of general practitioners and certain specialists in some areas of the state, and

WHEREAS, the *administration of the Medical Licensure Act seems on occasion to* restrict and discourage interns, residents and teaching fellows and general practitioners and specialists from coming to Indiana from other states which tends to reduce the quality and the proper number of physicians and educators,

NOW THEREFORE BE IT RESOLVED, that the *Indiana State Medical Association* request that the Medical Education and Licensure Commission, along with the Legislative Commission of the Indiana State Medi-

cal Association study, propose and vigorously support changes *in interpretation and administration of* the Medical Licensure Act to allow interns, residents, teaching fellows and qualified M.D.'s to secure more easily license in Indiana including the consideration of offering the necessary examination more than once a year, and to restudy the advisability of temporary licenses to qualified doctors of medicine.

Mr. Chairman, we move the adoption of Resolution No. 1, as amended.

(Motion seconded by Dr. Popp, discussed by Dr. Schuster, put to vote, and carried.)

Resolution No. 3

Introduced by: THE MARION COUNTY MEDICAL SOCIETY

Subject: TUBERCULIN TESTING OF PRE-SCHOOL CHILDREN

WHEREAS, eradication of tuberculosis long has been a goal of the medical profession, and

WHEREAS, a high percentage of the children in some elementary schools, particularly in urban areas, have not been tested for tuberculosis, and

WHEREAS, appeals to parents of some of the children voluntarily to arrange for them to be tested for tuberculosis have not achieved the desired results, and

WHEREAS, tuberculosis cannot be eradicated as long as such sources of infection are allowed to exist, and

WHEREAS, it is generally accepted by specialists in the field that tuberculin testing of children is the most effective way to find undetected cases.

NOW THEREFORE BE IT RESOLVED, that the Commission on Legislation of the Indiana State Medical Association be directed to seek legislation which will make it unlawful for any child in Indiana to enter first grade who cannot, or will not, provide written evidence that he has been tested for tuberculosis.

REFERENCE COMMITTEE ACTION

Dr. Herbert O. Chattin, chairman, continued with the report of the Reference Committee on Legislation:

Resolution No. 3. TUBERCULIN TESTING OF PRE-SCHOOL CHILDREN. Mr. Chairman, we move the adoption of this resolution.

(Motion seconded and adopted on a standing vote, 65 to 34.)

Resolution No. 7

Introduced by: VANDERBURGH COUNTY MEDICAL SOCIETY

Subject: COMMUNITY DUMPS

WHEREAS, the Indiana State Health Department is advocating that disposal of community waste products in open dumps be discontinued and supplanted by sanitary land fills, or by incineration, and

WHEREAS, this is desirable not only for health and hygienic reasons, but also for esthetic ones,

NOW THEREFORE BE IT RESOLVED that ISMA endorse the state health department position regarding community dumps, and,

BE IT FURTHER RESOLVED, that our officers and Commission on Legislation cooperate in promoting enactment of necessary legislation to accomplish this.

REFERENCE COMMITTEE ACTION

Dr. Herbert O. Chattin, chairman, presented the following report:

Resolution No. 7—COMMUNITY DUMPS. The reference committee recommend that the first WHEREAS, after "land fills, or by incineration, *or other method approved by the Indiana State Board of Health*" to the first WHEREAS, making it read as follows: (changes italicized)

"WHEREAS, the Indiana State Board of Health is advocating that disposal of community waste products in open dumps be discontinued and supplanted by sanitary land fills, or by incineration, *or other methods approved by the State Board of Health.*"

Mr. Chairman, we move the adoption of Resolution No. 7 as amended.

(Motion seconded by many, put to vote, and carried.)

Resolution No. 10

Introduced by: LAPORTE COUNTY MEDICAL SOCIETY

Subject: MEDICAL DIRECTOR, DEPARTMENT OF CORRECTION

WHEREAS, the State Board of Correction of the state of Indiana has within its jurisdiction the health of approximately 7,500 inmates; and

WHEREAS, the operation of the medical department of these institutions has shown certain deficiencies in selection of medical personnel and procurement of medical supplies and equipment

NOW THEREFORE BE IT RESOLVED, by the LaPorte County Medical Society that the medical needs of inmates of the institutions of the State Board of Correction of Indiana would be better met by the establishment of a medical department under the direction of a licensed physician within the State Board of Correction; such department having authority for the selection and direction of personnel, procurement of medical supplies and equipment; and

BE IT FURTHER RESOLVED, that this resolution be formally transmitted to the Indiana State Medical Association for consideration by the House of Delegates at the next session.

REFERENCE COMMITTEE ACTION

Dr. Herbert O. Chattin, chairman, presented the following report:

Resolution No. 10—MEDICAL DIRECTOR, DEPARTMENT OF CORRECTION. Mr. Chairman, we approve this resolution and move its adoption.

(Motion seconded by many, put to vote, and carried.)

Resolution No. 13

Introduced by: FORT WAYNE (ALLEN COUNTY) MEDICAL SOCIETY

Subject: RECOMMENDATIONS ON ISSUANCE OF DRIVER'S LICENSES

WHEREAS, the number of motor vehicle accidents in relationship to the number of miles driven is vastly higher in operators under 18 years of age than in any other age group,

NOW THEREFORE BE IT RESOLVED, that the Indiana State Medical Association recommend to the legislature of the state of Indiana that driver's education permits and beginner's permits shall not be issued to any person under the age of 16 years and that regular operator's permits may not be issued to any person under the age of 18 years, and that persons under the age of 18 years may not operate a motor vehicle except in the company of a regularly licensed operator over the age of 21 being present in the front seat of the automobile.

REFERENCE COMMITTEE ACTION

Dr. Herbert O. Chattin, chairman, presented the following report:

Resolution No. 13—RECOMMENDATIONS ON ISSUANCE OF DRIVER'S LICENSES. We recommend that Resolution No. 13 having to do with issuance of driver's license be referred to the Commission on Legislation for further study and action with the recommendation that proper legislation be prepared to permit persons between the ages of 16-18 to have drivers' training education and beginners' permits without adult supervision providing they are enrolled in school and have safe driver's records.

Mr. Chairman, we move the adoption of this section of the report.

(Motion seconded by many, put to vote, and carried.)

Resolution No. 14

Introduced by: FORT WAYNE (ALLEN COUNTY) MEDICAL SOCIETY

Subject: LICENSING OF OPERATORS OF MOTORCYCLES

WHEREAS, the number of motorcycle accidents has risen alarmingly within the past few years, and

WHEREAS, the proportion of victims of such accidents is extremely high in the under 18 age group, and

WHEREAS, operation of the motorcycle or other two-wheeled motor vehicle requires as great an amount of skill as operation of an automobile,

NOW THEREFORE BE IT RESOLVED, that the Indiana State Medical Association recommend to the legislature of the state of Indiana that two-wheeled motor vehicles of any type may not be operated on the public highways except by persons holding a regular (not a beginner's or driver's education) operator's permit.

REFERENCE COMMITTEE ACTION

Dr. Herbert O. Chattin, chairman, presented the following report:

Resolution No. 14—LICENSING OF OPERATORS OF MOTORCYCLES. This reference committee recommends the addition of the following to Resolution No. 14:

"*BE IT FURTHER RESOLVED, that crash helmets and other safety devices be required.*"

Mr. Chairman, we move the adoption of this resolution as amended.

(Motion seconded).

Discussed by Dr. Hill, Miami County, who moved that the following amendment also be added to Resolution No. 14:

"*BE IT FURTHER RESOLVED that similar study be given to the licensing of high speed motor boat (inboard and outboard) operators.*"

(Motion seconded, put to vote, and amendments adopted).

Dr. Chattin's motion for adoption of this resolution as amended by the Committee on Legislation and by Dr. Hill's motion was seconded, was put to vote, and carried.

Resolution No. 25

Introduced by: THE VANDERBURGH COUNTY MEDICAL SOCIETY

Subject: STATE SUBSIDIES FOR FULL-TIME LOCAL HEALTH DEPARTMENTS

WHEREAS, many areas in the state of Indiana do not have the basic health services as provided by a full-time health department, and,

WHEREAS, local taxation is becoming prohibitive, thus denying these basic services to many counties, and,

WHEREAS, the medical profession has an interest in that these preventive services should be available to all citizens of Indiana,

NOW THEREFORE BE IT RESOLVED, that the Indiana State Medical Association endorse in principle, state subsidies to local jurisdictions for the support of full-time health departments, and,

BE IT FURTHER RESOLVED, that our officers and Commission on Legislation actively promote the enactment of necessary legislation to accomplish this.

REFERENCE COMMITTEE ACTION

Dr. Herbert O. Chattin, chairman, presented the following report:

Resolution No. 25—STATE SUBSIDIES FOR FULL-TIME LOCAL HEALTH DEPARTMENTS.

Mr. Chairman, we approve this resolution and we move its adoption.

(Motion seconded by many, discussed by Dr. Bridges, Allen County, and Dr. Dalton, Shelby County, put to vote, and carried.)

Resolution No. 32

Introduced by: THE COUNCIL

Subject: IMPLEMENTATION OF TITLE XIX

WHEREAS, a proposed bill to implement Title XIX of Public Law 89-97 will be introduced in the 1967 session of the Indiana state legislature, and,

WHEREAS, there is some confusion regarding the impact of this legislation in relation to the welfare of the citizens of this state and the duties and obligations of the medical and allied professions who must implement the law, and

WHEREAS, the Indiana State Medical Association is primarily concerned with the adequate provision of high quality medical care for the people of the state of Indiana, and

WHEREAS, as principal provider of medical care in this state, the physicians of Indiana feel that they should be a principal participant in all planning or legislative action involved with the provision of medical care for our people; and

WHEREAS, the Indiana State Medical Association is concerned with the overall impact of the passage of laws to implement Title XIX.

NOW THEREFORE BE IT RESOLVED, that this House of Delegates of the Indiana State Medical Association adopt the following principles in regard to the implementation of Title XIX legislation in the state of Indiana:

1. The right of the patient to select his own physician and medical facility be guaranteed;
2. There be adequate representation of practicing physicians on the medical advisory committee to the state and local welfare departments and that the state or appropriate county medical society be consulted in regard to such appointments;
3. That there be a full time doctor of medicine as medical director in the state welfare department;
4. The patient not be required to have prior authorization in order to obtain emergency medical service;
5. The principle for reimbursement of physicians be on a usual and customary fee basis and that mechanics be included to permit direct billing of the patient by the physician;
6. A non-profit or other health insurance carriers be utilized in the implementation of these programs.

REFERENCE COMMITTEE ACTION

Dr. Herbert O. Chattin, chairman, presented the following report:

Resolution No. 32—IMPLEMENTATION OF TITLE XIX. Mr. Chairman, your reference committee approves this resolution and we move its adoption.

(Motion seconded by many).

(The chairman read the resolution in its entirety, at the request of the House. **The motion was then put to vote, and carried.)**

REFERENCE COMMITTEE ACTION

Dr. Chattin continued with the report of the Reference Committee on Legislation:

Mr. Chairman, we move the adoption of this report as a whole.

(Motion seconded by many, put to vote, and carried.)

I would like very much to thank the members who appeared before this committee to testify and I also wish to thank my fellow physicians who were on this committee with me, Dr. Warren McClure, Dr. Thomas Armstrong, Dr. Ray Burnikel, and Dr. Wallace R. Van Den Bosch.

PUBLIC RELATIONS

The following matters were referred to the Reference Committee on Public Relations. All reports with the exception of the Grievance Committee report and the supplemental report of the Commission on Inter-Professional Relations will be found on the pages indicated in the September, 1966, Vol. 59, *Journal of the Indiana State Medical Association.* Resolutions introduced before the House and referred to this committee are printed herewith.

Grievance Committee (printed herewith)

Medical-Legal Review Committee (no written report)

Commission on Public Information (pages 1065-66)

Commission on Inter-Professional Relations (page 1071) and supplemental report (printed herewith)

Commission on Aging (pages 1072-73)

Resolution No. 17—DEFINING ETHICS WITH REGARD TO PRESCRIPTION OF MEDICATION

Grievance Committee Report 1965-1966

The Grievance Committee held meetings on November 14, 1965 and April 13, 1966.

As of July 1, 1966, 12 cases have been considered during the preceding 12 months. Of the 12 cases referred to the physician named in the complaints, one was settled to the satisfaction of the complainant and several of the remaining cases await only ratification by the Grievance Committee at its next meeting to make settlement official. Three of the above cases required referral to the county medical societies for jurisdiction from whom we have had no report as yet. There were nine cases pending as of July, 1965, and all of these have been closed.

Cases reported to the ISMA Grievance Committee since 1958 have been handled by the usual procedure of: (1) The complainant is requested to approve the forwarding of a full copy of the complaint in which he is identified to the physician or physicians named in the complaint. The complainant is informed that failure to give this permission must terminate the complaint. In those rare instances where the practice is reported as a pernicious one and the evidence convincing, the ISMA Grievance Committee must, under its rules, proceed with its investigation despite refusal of permission to forward the specific complaint and the identity of the complainant. The physician named is thus given the opportunity to refute any serious charge made against him. (2) If permission is received the complaint is forwarded to the physician along with a suggestion that he attempt to settle the issue with the complainant. (3) Should the physician be unsuccessful or decline to act, the complaint is forwarded to his county medical society with a request that it attempt to adjudicate the matter. (4) If the county society declines to act, is unable to resolve the issues or if the matter is a multiple county problem, the ISMA Grievance Committee proceeds with the adjudication effort.

We wish to remind all county medical society officers of the action of the 1962 House of Delegates directing that the secretary of any county society which has taken disciplinary action against a physician report this to the ISMA Grievance Committee for its confidential record. A second reminder is of the 1963 House of Delegates action which makes it incumbent upon every physician to report to his county medical society grievance committee for its action the collaboration of any ISMA member with any person who engages in the practice of medicine without a license. This includes attempts to diagnose or treat emotional or mental illness other than under the direct supervision of a physician.

Lastly is an item of importance from the AMA First National Congress on Medical Ethics held March 5 and 6, 1966. The following conditions for all disciplinary hearings at both the county and state level were recommended: (1) Investigative hearings should be informal and may proceed without the presence of legal counsel although the physician against whom a complaint has been lodged may properly have this attorney present to give him advice. (2) Disciplinary hearings more especially those which carry the possibility of recommending that a physician be suspended or dropped from membership should be conducted in a more formal manner. The physician charged should be notified by registered mail of his right to legal counsel at the hearing. This is to guard against reversal of the findings at any later hearing. An attorney should be present to advise the officers of the society conducting the hearing. The attorneys are not to dominate the hearing but to advise the respective parties. (3) Disciplinary hearings should be recorded by a stenographer or other competent person as to all pertinent remarks as well as findings and recommendations. This record should be preserved in a confidential file. In Indiana where action is taken against a physician, the ISMA Grievance Committee is to be notified as previously mentioned.

The Grievance Committee thanks all ISMA members who as individuals or committee members responded in cooperative fashion to our efforts to discharge our assigned responsibility during 1965-66.

PHILIP B. REED, M.D., *Chairman*
EARL W. MERICLE, M.D., *Vice-Chairman*
H. ALLISON MILLER, M.D., *Secretary*
MARVIN L. McCLAIN, M.D.
GUY A. OWSLEY, M.D.
MAURICE E. GLOCK, M.D.
RAYMOND E. NELSON, M.D.
HUGH B. McADAMS, M.D.
WILLIAM R. CLARK, M.D.
WILLIAM R. NOE, M.D.

REFERENCE COMMITTEE ACTION

Dr. Lowell Painter, chairman, presented the following report:

The following matters were referred to the Reference Committee on Public Relations:

1. *Report of Grievance Committee.* Mr. President, this committee recommends that the annual report of the Grievance Committee be adopted and this report be filed and the committee be commended. Mr. President, I so move.

(Motion seconded, put to vote, and carried.)

2. *Report of Medical-Legal Review Committee.* No report was received from this committee.

3. *Report of Commission on Public Information.* We would like to point out that even though all county societies are aware of the fine programs provided by the Committee on Public Information, or we hope that they are, the public image of the physician is an individual responsibility. We recommend the report of the Public Information Commission be adopted and that this commission be commended.

The suggestion was made that the services of each local medical society be readily available to press and other news media for giving background information on any medical release.

Mr. President, I move the adoption of this portion of this report.

(Motion seconded by many, put to vote, and carried.)

4. *Report of Commission on Inter-Professional Relations.* This committee would amend this report to include the recommendation that the Commission on Inter-Professional Relations initiate the formation of an Indiana Association of Professions in the very near future using the Michigan State Medical Society operation as a guideline. We recommend the professions should be limited to the six oldest and time-honored professions, namely, engineers, architects, lawyers, dentists, veterinarians and physicians (at least to start with.)

We should like to call the attention of the House to a misprint in the Handbook, page 114, under the report of the Commission on Inter-Professional Relations, second paragraph, last line, should read *Indiana Veterinarian Association.*

Mr. President, we move the adoption of this section of the report as amended.

(Motion seconded, put to vote, and carried.)

Supplemental Report of the Commission on Inter-Professional Relations

The initial draft of the Physician-Pharmacist Code, as formulated by the Commission on Inter-Professional Relations of the state medical association and a like committee of the Pharmaceutical Association, was adopted by the House of Delegates of the Indiana State Medical Association in October, 1965.

Following the adoption of the code, the Indiana Pharmaceutical Association had its

85th annual convention in June of 1966 and adopted some additional amendments to the code and presented them again to the Commission on Inter-Professional Relations for action. Upon receipt of these recommendations of the Indiana Pharmaceutical Association, the commission circulated to its members, the code and a copy of the recommended amendments requesting a vote on each amendment.

The following is a draft of the Physician-Pharmacist Code of Understanding:

Draft

Physician-Pharmacist Code of Understanding
Indiana State Medical Association
Indiana Pharmaceutical Association

Preamble

The purpose of this Code of Understanding is to restate and reaffirm the ethical principles of each profession and to strengthen relations between doctors of medicine and pharmacists.

This Code of Understanding is not a pronouncement of law, but constitutes suggested rules of conduct for the members of these two health professions subject to the principles of ethics governing the members of the respective organizations and rules of law prescribed for their individual conduct.

This code constitutes the recognition that physicians and pharmacists are interdependent in serving the patient and have a joint responsibility of educating the public in the proper use and handling of medications.

Prescribing Medication

Sec. 1. A prescription is the continuation of the physician's diagnosis and treatment. In order to properly meet the medical needs of the patient a prescription should be written by the physician and dispensed by the pharmacist with care and in accordance with federal and state laws.

Sec. 2. Both the physician and the pharmacist recognize that the refilling of any prescription constitutes the continuation of the physician's treatment of his patient and therefore in giving refill authorizations and in refilling prescriptions the practitioners use the same care and precaution as with a new prescription.

Sec. 3. The physician has the responsibility and prerogative of selecting the medication he prefers. When a brand is not specified, the pharmacist has the responsibility of selecting drugs which in his professional judgment are of good quality.

Sec. 4. The sale or purchase of samples is unethical.

Dispensing Medication

Sec. 1. The pharmacist recognized his obligation to the physician and his patient to compound and dispense prescriptions carefully and accurately as ordered by the physician. Should an occasion arise when the pharmacist might suspect that an error has been made concerning the ingredients, dosage or directions for use, he should consult the prescribing physician for clarification and verification prior to dispensing the prescription. Such consultations should be privately made and the pharmacist shall protect the interest of the patient. Pharmacists recognize that the physician must have the confidence of his patient and that inquiries concerning errors in prescriptions must be treated as confidential matters between practitioners.

Sec. 2. Pharmacists should use extreme discretion in conversing with patrons regarding the composition of their prescriptions and should refrain from speculating with the patient regarding the condition for which the medication is prescribed or the physician's course of treatment. If such questions arise, the pharmacist should diplomatically suggest that the physician is the proper person with whom such matters should be discussed.

Sec. 3. The pharmacist should not diagnose or prescribe, even at the insistence of a patient, but should refer those seeking medical information or attention to a physician of the patient's choice. The sale of reputable proprietary products and home remedies that are approved by the federal Food and Drug Administration for over-the-counter sale shall not be considered counter prescribing by the pharmacist when the patron may request the item for self medication.

Sec. 4. A physician should not advise a patient as to the exact charge for a prescription any more than a pharmacist should advise a patient of charges for physician's services.

Freedom of Choice

Sec. 1. Both professions should strive to afford the patient, at all times, free choice of medical and pharmaceutical services.

Sec. 2. Prescription blanks imprinted with the name of a pharmacy, referral of a patient to a specific pharmacist by a physician or referral of a patron to a specific physician by a pharmacist is construed as limiting freedom of choice. These practices are condemned.

Physician Dispensing

Sec. 1. Each profession recognizes that the physician has the right, ethically and legally of supplying his patients with needed drugs, remedies or appliances as long as there is no exploitation of the patient. However, the physician should recognize the specialized education and training of the pharmacist and should utilize his services whenever it serves the best interest of the patient.

Information Service to Physicians

Sec. 1. The pharmacist, as a ready and impartial source of drug information, should unhesitatingly make such information available to the physician so that the patient may benefit.

Patient Communications

Sec. 1. Knowledge or information acquired by the pharmacist regarding the ailments of the patient are entrusted to his confidence as they are to the physician's and should never be divulged without the patient's consent, unless the practitioner is compelled to do so by law, or in the interest of the patient.

Consideration and Disposition of Complaints or Disputes

Sec. 1. Complaints or disputes, including complaints of the violation of the principles of this code are to be referred by the complaining physician or pharmacist to his local professional society whereupon representatives of the respective local societies will attempt to resolve the dispute. (The following are the recommended amendments of the Indiana Pharmaceutical Association.)

Indiana Pharmaceutical Association, Inc.
85th Annual Convention

Inter-Professional and Public Health Committee Report

Amendments to Pharmacist-Physician Code of Understanding

Dispensing Medication, Section 1, page two, add the following:

Should an occasion arise where a patient expresses concern to the physician regarding a possible error in the dispensing of a prescription, the prescribing physician should contact the pharmacist at the pharmacy where the prescription was dispensed, for clarification. This consultation should be handled with discretion in order that the patient's confidence in both the pharmacist and the physician is maintained.

Dispensing medication, Section 4, delete the word, "exact"

Physician dispensing, Section 1, delete the words, "it serves the best interest of the patient," and insert in lieu thereof: "possible."

Concerning the first suggested amendment by the Indiana Pharmaceutical Association, dealing with dispensing medication, Section 1, the commission voted 13 to 0 for acceptance. Concerning the second suggested amendment, dealing with dispensing medication, section IV, the commission members voted 11 to 2 for the amendment. Concerning the third amendment, dealing with

physician dispensing, section I, the commission members voted 8 to 5 for adoption. The commission hereby submits, in its report, this information for action by the House of Delegates of the Indiana State Medical Association.

REFERENCE COMMITTEE ACTION

Dr. Painter, chairman, continued with the report of the Reference Committee on Public Relations:

5. *Supplemental Report of Commission on Inter-Professional Relations.* Mr. President, this committee recommends the adoption of the supplementary report of the Commission on Inter-Professional Relations. This has to do with the code between the pharmacist and the physician, and I so move.

(Motion seconded, put to vote, and carried.)

6. *Report of Commission on Aging.* Mr. President, this committee recommends the adoption of the report of the Commission on Aging and the committee be commended on their splendid efforts. Mr. President, I so move.

(Motion seconded by many, put to vote, and carried.)

Resolution No. 17

Introduced by: THE COUNCIL
Subject: DEFINING ETHICS WITH REGARD TO PRESCRIPTION OF MEDICATION

WHEREAS, some criticism has been directed toward the health professions because of alleged inter-relationships between physicians who prescribe medication or therapeutic devices and those who fill them, whereby financial benefits may accrue to the prescriber, and

WHEREAS, organized medicine has long advocated complete freedom of choice for our patients in seeking and obtaining all aspects of their health care, and

WHEREAS, we believe that most practitioners are presently acting fully in accord with this principle,

NOW THEREFORE BE IT RESOLVED, that the Indiana State Medical Association urges each of its members to review all present or projected methods of providing medications or devices with careful attention to any possible encroachment of the patient's right of complete free choice in selecting the source of prescribed agents, and

BE IT RESOLVED, that if such actual or potential abridgement of this freedom be discovered, it be promptly corrected, and

BE IT FURTHER RESOLVED, that each component medical society be asked to take appropriate measures to promote these objectives.

REFERENCE COMMITTEE ACTION

Dr. Painter, chairman, presented the following report:

7. *Resolution No.* 17—We should be cognizant of the national legislation being pushed by Senator Hart and be aware of the discriminatory content against the ophthalmologists as well as other medical groups. Mr. President, this committee recommends the adoption of Resolution No. 17, and I so move.

Mr. President, I move the adoption of this report as a whole.

(Motion seconded by many, put to vote, and carried.)

The chairman would like to thank the members of this committee; they were all present: Betty Dukes, Richard R. Eggers, S. E. Bechtold, and David Hadley.

HYGIENE AND PUBLIC HEALTH

The following matters were referred to the Reference Committee on Hygiene and Public Health. All reports will be found on the pages indicated in the September, 1966, Vol. 59, *Journal of the Indiana State Medical Association* with the exception of the Maternal Mortality Study report, copy of which was handed to each delegate, and the report of the Commission on Special Activities. This commission did not submit a report. Resolutions introduced before the House and referred to this committee are printed herewith.

Commission on Public Health (pages 1067-68)

Commission on Voluntary Health Agencies (page 1069)

Commission on Special Activities (no printed report)

Maternal Mortality Study report (copy handed to each delegate)

Resolution No. 26—A BILL FOR AN ACT PUTTING THE INSPECTION OF DAIRY FARMS, MILK HAULERS AND DAIRY PROCESSING PLANTS UNDER STATE JURISDICTION

Resolution No. 27—MEAT INSPECTION

REFERENCE COMMITTEE ACTION

Dr. W. Lloyd Bridges, chairman, presented the following report:

1. *Report of Commission on Public Health* Our committee accepted the report of the Commission on Public Health. We feel it is important that all new physicians in Indiana receive all pertinent publications of the ISMA relative to medical practice and legal requirements peculiar to the state of Indiana.

We wish to commend the continued sponsorship of the annual Junior-Senior Day.

We feel that a meeting between the ISMA and the Indiana Association of Public School Superintendents could be very valuable in creating better understanding and working relationships in the area of school health. This is a very important area because of increased federal interest in school health.

Mr. Chairman, I move the adoption of this section of the report.

(Motion seconded by many, put to vote, and carried.)

2. *Report of Commission on Voluntary Health Agencies.* Our committee accepts the report of the Commission on Voluntary Health Agencies. We noted and wish to commend the commission for its large meeting which was held with the voluntary health agencies. We believe such meetings are of material benefit to both the ISMA and the voluntary health agencies.

Mr. Chairman, I move the acceptance of this portion of the report.

(Motion seconded, put to vote, and carried.)

3. *Report of Commission on Special Activities.* Our reference committee noted the absence of any report by the Commission on Special Activities. We observed that this commission has responsibility in certain regions such as blood banks, promotion of support for the American Medical Education Fund and perhaps other important areas. Our committee was concerned that there was no report on the year's activities of this commission.

Mr. Chairman, I move the adoption of this section of the report.

(Motion seconded, put to vote, and carried.)

4. *Maternal Mortality Study Report.* The report of the Maternal Mortality Study Committee of the ISMA was reviewed.

This continuing study is a valuable tool, used by the O.B. Department of the I.U. Medical School for teaching purposes, and, it also serves as a yardstick to measure the quality of care in our hospitals throughout the state.

The Maternal Mortality Study Committee is to be commended for its comprehensive study and urged to continue to report its findings.

Mr. Chairman, I move the adoption of this portion of the report.

(Motion seconded, put to vote, and carried.)

Resolution No. 26

Introduced by: VANDERBURGH COUNTY MEDICAL SOCIETY
Subject: A BILL FOR AN ACT PUTTING THE INSPECTION OF DAIRY FARMS, MILK HAULERS AND DAIRY PROCESSING PLANTS UNDER STATE JURISDICTION

WHEREAS, the medical profession is

concerned with having a safe milk supply for the citizens of Indiana, and,

WHEREAS, the source of milk supply is reaching more and more into distant parts of the state and into other states, and,

WHEREAS, it is becoming increasingly difficult to support the necessary inspection services by the local health department through local taxation,

NOW THEREFORE BE IT RESOLVED, that the Indiana State Medical Association endorse proposed legislation for the provision of these necessary services by the State Board of Health to assure a safe milk supply and to provide for the interchange of such inspection services between our state and other states, and,

BE IT FURTHER RESOLVED, that our officers and Commission on Legislation cooperate in promoting the enactment of such legislation.

REFERENCE COMMITTEE ACTION

Dr. W. Lloyd Bridges, chairman, continued with the report of the Reference Committee on Hygiene and Public Health:

5. *Resolution No.* 26—INSPECTION OF DAIRY FARMS. Our committee supports Resolution 26 and notes that there is now overlapping of many milk shed areas and that different milk sanitarians must cover the same area. Apparently this inefficient use of scarce milk sanitarian manpower is increasing.

Mr. Chairman, I move the adoption of this resolution.

(Motion duly seconded. Discussed by Drs. Hedgcock, Corcoran, Dalton and Rosenbloom. **The resolution was defeated on voice vote; all noes.)**

Resolution No. 27

Introduced by: VANDERBURGH COUNTY MEDICAL SOCIETY

Subject: MEAT INSPECTION

WHEREAS, it is recognized that infected or contaminated meats can be a source of human disease or illness, and,

WHEREAS, there are abattoirs and meat processing plants in the state of Indiana that do not have approved meat inspection programs, and,

WHEREAS, many citizens are not aware that they may be eating uninspected meats, and,

WHEREAS, some local communities either cannot afford, or will not provide the necessary services to assure as safe a meat supply as possible,

NOW THEREFORE BE IT RESOLVED, that the Indiana State Medical Association endorse a state meat inspection program, and,

BE IT FURTHER RESOLVED, that our officers and appropriate commissions cooperate in promoting the provisions of these services and the possible enactment of necessary legislation to accomplish this.

REFERENCE COMMITTEE ACTION

Dr. W. Lloyd Bridges, chairman, presented the following report:

6. *Resolution No.* 27—MEAT INSPECTION. We support Resolution 27. We believe that it is very important that all meat and poultry offered for sale to the public in the state of Indiana be properly inspected.

Mr. Chairman, I move that this resolution be passed.

(Motion seconded, and put to vote. The chairman called for a division of the House. Resolution No. 27 was adopted on vote of 56 to 22.)

Mr. Chairman, I move the adoption of this report as a whole, as amended.

(Motion seconded, put to vote, and carried.)

I wish to thank all witnesses who appeared before the committee, and the members of the reference committee, Drs. John Butler, Glen Ward Lee, Ramon DuBois and L. John Vogel, all of whom were present.

AMENDMENTS TO CONSTITUTION AND BYLAWS

The following matters were referred to the Reference Committee on Amendments to Constitution and Bylaws. All reports will be found on the pages indicated in the September, 1966, Vol. 59, *Journal of the Indiana State Medical Association*. Resolutions introduced before the House and referred to this committee are printed herewith.

Commission on Constitution and Bylaws (pages 1064-65)

Resolution No. 2—AMENDMENT TO CONSTITUTION AND BYLAWS TO PROVIDE ADDITIONAL CATEGORIES OF MEMBERSHIP

Resolution No. 6—REVISION OF COUNCILOR DISTRICTS OF ISMA

Resolution No. 12—AMENDMENT TO MEDICAL DEFENSE BYLAWS

REFERENCE COMMITTEE ACTION

Dr. Leslie M. Baker, chairman, presented the following report:

Your Reference Committee on Amendments to Constitution and Bylaws has examined the report of the Commission on Constitution and Bylaws recommending changes in the Bylaws as follows:

1. That Chapter IV—Section 8 of the Bylaws be amended by deleting the following: "or any changes in the Constitution and Bylaws." The section would then read as follows: Sec. 8. "The final vote on any issue calling for changes in dues or in dues structure shall be by roll call vote. Each member's vote shall be permanently recorded and no suspension of this rule will be allowed on the final vote of such an issue."

Mr. Chairman, I move this portion of the report be approved and adopted.

(Motion seconded).

Dr. Lloyd Hill, Miami County, moved that the following amendment be added to the amendment proposed by the Reference Committee on Constitution and Bylaws:

"A recorded roll call vote may be requested on changes to the Constitution and Bylaws by any member of the ISMA House of Delegates."

Dr. Lester Hoyt suggested that perhaps a signed ballot vote would answer the same purpose as a roll call vote and moved that the following be included in Dr. Hill's amendment: **"and this vote may be a written, signed ballot,"** which would make Dr. Hill's amendment read:

"A recorded roll call vote may be requested on changes to the Constitution and Bylaws by any number of the ISMA House of Delegates, and this vote may be a written, signed ballot."

Dr. Hill concurred in this addition and his motion was seconded, and the amendment was adopted on voice vote. The chair ruled that this portion of the report would lay on the table until the next meeting of the House of Delegates.

Dr. Hoyt announced that Judge Hamill had suggested that the House move to reconsider and that Dr. Hill's amendment be referred to the Commission on Constitution and Bylaws for study and report back next year.

Dr. Hoyt moved that the House reconsider Dr. Hill's amendment. Motion seconded, put to vote and carried.

On motion duly made and seconded, the House voted that Dr. Hill's recommendations regarding amendment of Chapter IV, Section 8, of the Bylaws be referred to the Commission on Constitution and Bylaws for study and for report back in 1967. Motion seconded, put to vote, and carried.

Dr. Baker's motion that paragraph No. 1 of the Reference Committee's report be approved and adopted as written, was adopted on a roll call vote of 110 to 4. (See roll call vote, pages 1547-50).

REFERENCE COMMITTEE ACTION

Dr. Leslie M. Baker, chairman, continued with the report of the Reference Committee on Amendments to Constitution and Bylaws:

2. That Chapter I of the Bylaws be amended by adding a new Section to be numbered Section 1 as follows:

"Sec. 1. Every county society shall in-

clude by January 1, 1967, as a part of their Constitution or Bylaws the following: Every person becoming an active member after January 1, 1967, shall occupy a provisional status for two years immediately following his admission to membership in this society, during which period he must successfully complete an orientation course to be presented at stated intervals by the Council of the Indiana State Medical Association or one of its commissions. The form and content of this course shall be prescribed by the Council of Indiana State Medical Association. Unless excused by the said Council for good cause shown, failure to attend and successfully complete the course within the two-year period shall automatically revoke the delinquent's membership and terminate all of his rights and privileges as a member, and he shall thereafter, for a period of one year, be ineligible for membership in any component county society."

The present sections of said Chapter 1 of the Bylaws shall be renumbered to follow in chronological and proper sequence.

Mr. Chairman, I move this portion of the report be approved and adopted.

(Motion seconded, and adopted on voice vote.)

3. That Chapter XXVIII, Section 1 of the Bylaws be amended by deleting the following words: "provided such members of county medical societies have paid their membership dues in the district society"—with this amendment said section will read as follows:

"Sec. 1. A Councilor District Medical Society, hereinafter called the district society, shall be a society whose members consist of the members of the county medical societies in the counties which constitute the Councilor District."

Mr. Chairman, I move this portion of the report be approved and adopted.

(Motion seconded, put to vote, and carried.)

4. That Chapter XXVII, Section 4 be amended by inserting after the first sentence and before the second and last sentence the following: "Provided, however, that each county society may deny membership in such society for infraction or violation of any law relating to the practice of medicine or of the Constitution and Bylaws of such society, the Constitution and Bylaws of the Indiana State Medical Association or for a violation of the Principles of Medical Ethics of the Indiana State Medical Association; and may, after due notice and hearing, censor, suspend or expel any member for any such infraction."

Mr. Chairman, I move this portion of the report be approved and adopted.

(Motion seconded, put to vote, and carried.)

5. That Chapter XXVII of the Bylaws be amended by deleting therefrom present Section 8, which now reads as follows: "A physician living on or near a county line may hold his membership in that county most convenient for him to attend, on permission of the society in whose jurisdiction he has his office or has the major part of his practice," and by substituting in lieu thereof the following:

"Sec. 8. A physician who has the major part of his practice in a county other than the county in which he resides may hold his membership in the county society of his residence or in the county society of the county in which he has the major part of his practice. However, no physician shall hold active membership in more than one county society at the same time."

Mr. Chairman, I move this portion of the report be approved and adopted.

(Motion seconded, put to vote, and carried.)

Your reference committee has further examined the Report of the Commission on Constitution and Bylaws recommending changes in the Constitution which should be voted upon at this time but must lay over for action one year from now. The amendments are as follows:

(1) That Article IV, Section 2, of the Constitution be amended by inserting after the word "the" in the last line the following words "District Medical Society and in", which would make this section read as follows:

"Sec. 2 — *Active Members* — The active members of this association shall be the members of the component county medical societies, and no county medical society shall grant active membership therein on a basis that does not include membership in the district medical society and in the Indiana State Medical Association."

Mr. Chairman, I move this portion of the report be approved and adopted.

(Motion seconded, put to vote, and carried.)

(2) That Article VII of the Constitution be amended by inserting after the words, "such societies to be composed exclusively of" and before the word, "members" the word "all" which would make the article read as follows:

"Article VII — The House of Delegates may provide for a division of the scientific work of the association into appropriate sections; and for the organization of such Councilor District Societies as will promote the best interests of the profession, such societies to be composed exclusively of all members of component county societies. Councilor districts shall be defined by the House of Delegates."

Mr. Chairman, I move this portion of the report be approved and adopted.

(Motion seconded, put to vote, and carried.)

Resolution No. 2

Introduced by: THE MARION COUNTY MEDICAL SOCIETY

Subject: AMENDMENT OF THE CONSTITUTION AND BYLAWS TO PROVIDE ADDITIONAL CATEGORIES OF MEMBERSHIP

WHEREAS, organized medicine should embrace every eligible physician, and,

WHEREAS, increases in the amount of the annual dues of the Indiana State Medical Association, the American Medical Association and some county medical societies have been effected, and,

WHEREAS, there are physicians in various governmental and teaching situations whose income is restricted and who have not become members of these medical groups because of the total expense,

NOW THEREFORE BE IT RESOLVED, that the House of Delegates of the Indiana State Medical Association establish membership categories for such physicians by amendment of the Constitution and Bylaws and require payment by them of a lesser amount of annual dues than is required of other active members.

REFERENCE COMMITTEE ACTION

Dr. Leslie M. Baker, chairman, presented the following report:

This reference committee has had referred to it Resolution No. 2 having to do with amendments of the Constitution and Bylaws to provide additional categories of membership.

Discussion of this resolution revealed that the resolution does not define specifically which physicians should be given such consideration and further discussion also points up much uncertainty as to the merits of such preferential classification. It is, therefore the recommendation of this committee that this resolution be referred to appropriate commission for further study.

Mr. Chairman, I move the approval and adoption of this portion of the report having to do with Resolution No. 2.

(Motion seconded, put to vote, and carried.)

Resolution No. 6

Introduced by: MARION COUNTY MEDICAL SOCIETY

Subject: REVISION OF COUNCILOR DISTRICTS OF THE INDIANA STATE MEDICAL ASSOCIATION

WHEREAS, present councilor districts of

the Indiana State Medical Association are based on certain geographical boundaries and, thus, are not representative of the membership numerically, and,

WHEREAS, the Council, which has full charge and control of all property of the association and which is the governing body of the organization between sessions of the House of Delegates, should represent the membership on a more equitable basis, and,

WHEREAS, as present districts are defined, one councilor represents as few as 138 members and another as many as 1,127, as indicated in the official membership report of the association as of December 31, 1965, and,

WHEREAS, seven of the thirteen councilors represent a total of 1,300 members and the other six represent a total of 3,096 members, again revealing inequity of representations, and,

WHEREAS, this inequitable distribution of membership in the councilor districts also is reflected in the various commissions of the association and in the Board of Directors of Blue Shield, whose members, except for the members-at-large, are chosen by councilor districts, and,

WHEREAS, the Constitution and Bylaws of the association provides that there shall be thirteen councilors but does not define the councilor districts, and the definition of the districts is the duty of the House of Delegates,

NOW THEREFORE BE IT RESOLVED, that the House of Delegates of the Indiana State Medical Association redefine the councilor districts so that each councilor represents approximately 300 members of the association, except that in any county in which the medical society has a large membership, each 300 members shall constitute a district and one group of officers shall be elected to serve the combined districts, and,

BE IT FURTHER RESOLVED, that councilor districts shall be redefined as follows:

BE IT FURTHER RESOLVED, that implementation of this resolution shall be accomplished in the following manner:

1st District. The present councilor shall continue to serve until his term of office expires, in 1968, at which time the district shall reorganize and a new councilor shall be elected.

The alternate councilor, to be elected from the present district in 1967, shall continue until his term of office expires, in 1969. His successor shall be elected by the reorganized district.

2nd District. The present councilor shall continue to serve until his term of office expires, in 1969, at which time the district shall reorganize and a new councilor shall be elected.

The alternate councilor, whose term of office expires in 1968, shall continue to serve until 1970, when his successor shall be elected by the new district.

3rd District. The present councilor shall continue to serve until his term of office expires, in 1967, at which time the district shall reorganize and a new councilor shall be elected.

The alternate councilor shall continue to serve until his term of office expires, in 1968, at which time his successor shall be elected by the reorganized district.

4th District.

5th District.

7th District. The present councilors from the 4th, 5th and 7th districts shall continue to serve until their terms of office expire, in 1968, at which time the districts shall reorganize and elect new councilors.

The alternate councilor from the 4th district shall continue to serve until 1969, when the reorganized district shall elect a new alternate councilor.

The alternate councilor from the 5th district shall continue to serve until his term of office expires, in 1969, at which time the reorganized district shall elect a new alternate councilor.

The alternate councilor from the 7th district shall continue to serve until his term of office expires, in 1969, at which time the reorganized district shall elect a new alternate councilor.

6th District. The present councilor shall continue to serve until his term of office expires, in 1967, at which time the district shall reorganize and a new councilor shall be elected.

The alternate councilor shall continue to serve until his term of office expires, in 1969, at which time the reorganized district shall elect a new alternate councilor.

8th District. The present councilor shall continue to serve until his term of office expires, in 1969, when the district shall reorganize and a new councilor shall be elected.

The alternate councilor shall continue to serve until 1970, at which time the reorganized district shall elect a new alternate councilor.

9th District. The present councilor shall serve until his term of office expires, in 1967, at which time the district shall reorganize and elect his successor.

The alternate councilor shall serve until his term of office expires, in 1968, at which time the reorganized district shall elect his successor.

10th District. The present councilor shall serve until his term of office expires, in 1968, at which time the district shall reorganize and elect his successor.

The present alternate councilor shall serve until his term of office expires, in 1969, at which time the reorganized district shall elect his successor.

11th District. The present councilor shall serve until his term of office expires, in 1969, at which time the district shall reorganize and elect his successor.

The present alternate councilor shall serve until his term of office expires, in 1970, at which time the reorganized district shall elect his successor.

12th District. The present councilor shall serve until his term of office expires, in 1967, at which time the district shall reorganize and elect his successor.

The present alternate councilor shall serve until his term of office expires, in 1968, at which time the reorganized district shall elect his successor.

13th District. The present councilor shall serve until his term of office expires, in 1968, at which time the district shall reorganize and elect his successor.

The present alternate councilor shall continue to serve until 1969, at which time the reorganized district shall elect his successor.

This plan will provide for 13 councilors at all times. Four will be elected in 1967; six in 1968 and three in 1969. Thus, in 1969, all councilors will represent the new districts as defined by this resolution.

BE IT FURTHER RESOLVED, that each newly organized district shall determine the proper procedure for it to follow in election of its representative on the Blue Shield Board of Directors.

BE IT FURTHER RESOLVED, that when the membership in any district or county society arrives at a point where 200 or more members are not represented by a councilor on the basis of one councilor for each 300 members, the House of Delegates shall again reconsider defining councilor districts.

1st District

Posey	10
Vanderburgh	236
Warrick	7
Spencer	4
Perry	9
Gibson	15
Pike	4
Knox	38
Daviess-Martin	20
Total Members	343

2nd District

Parke-Vermillion	23
Putnam	15
Vigo	120
Clay	11
Sullivan	15
Greene	16
Owen-Monroe	61
Hendricks	22
Morgan	18
Total Members	301

3rd District

Dubois	24
Lawrence	24
Orange	9
Harrison-Crawford	11
Floyd	37
Clark	40
Scott	4
Washington	7
Jackson-Jennings	24
Bartholomew-Brown	46
Decatur	11
Jefferson-Switzerland	28
Dearborn-Ohio	20
Ripley	9
Total Members	294

4th, 5th and 7th Districts

Marion	1,058

6th District

Johnson	29
Shelby	20
Hancock	22
Rush	14
Fayette-Franklin	16
Jay	15
Randolph	21
Henry	39
Wayne-Union	68
Total Members	244

8th District

Madison	101
Delaware-Blackford	124
Grant	70
Wells	37
Adams	14
Total Members	346

9th District

Porter	32
Starke	7
Jasper	7
Newton	5
White	12
LaPorte	100
Pulaski	5
Benton	9
Fountain-Warren	15
Tippecanoe	125
Montgomery	27
Total Members	344

10th District

Lake	440

11th District

LaGrange	7
Huntington	25
Marshall	27
Carroll	8
Clinton	20
Noble	17
Wabash	25
Fulton	11
Miami	14
Boone	19
Hamilton	24
Whitley	17
Kosciusko	19
Cass	37
Howard	68
Tipton	11
Total Members	349

12th District

Allen	294
DeKalb	23
Steuben	14
Total Members	331

13th District

St. Joseph	236
Elkhart	108
Total Members	344

REFERENCE COMMITTEE ACTION

Dr. Leslie M. Baker, chairman, presented the following report:

Your reference committee has had referred to it Resolution No. 6 having to do with revision of councilor districts of ISMA.

Four of our district councilors, the immediate past-president of the Marion County Medical Society and several interested members of the association participated in this discussion. There was a general area of agreement by all that "something needs to be done" to strengthen the functions of the districts; to encourage all component county medical societies and their individual members to participate fully in the election and support of their councilor; to effect an image in the Council of unified, harmonious concern for organized medicine, without the blight of sectionalism, either geographic or urban vs. rural.

The Marion County Medical Society is to be commended for bringing these matters to the attention of the ISMA. It is felt that the actual mechanics of effecting these aforementioned changes may not be accomplished per se by the resolution, as submitted. Your committee, therefore, recommends that this matter be referred to appropriate commission for further study.

Mr. President, I move for the adoption of this portion of the report.

(Motion seconded by many, put to vote, and carried.)

Resolution No. 12

Introduced by: FORT WAYNE (ALLEN COUNTY) MEDICAL SOCIETY

Subject: AMENDMENT TO MEDICAL DEFENSE BYLAWS

BE IT RESOLVED that the Constitution of the Indiana State Medical Association be amended to include under Chapter XXX — Medical Defense — a section which states that the medical defense funds of the association may be used to support the suit of any physician whose staff privileges have been removed or who is discriminated against in regard to admission of patients or surgical scheduling because of failure to complete any formal or informal statements required either by the Social Security Administration or the fiscal intermediary in order that the hospital may receive governmental reimbursement for medicare patients which have been hospitalized therein.

FURTHERMORE, that the Commission on Constitution and Bylaws shall be charged with the exact wording of such a selection.

REFERENCE COMMITTEE ACTION

Dr. Leslie M. Baker, chairman, continued with the report of the Reference Committee on Amendments to the Constitution and Bylaws:

In reference to Resolution No. 12 having to do with amendment to medical defense bylaws, it was the opinion of the committee that this area may be contingent upon action of other committees and, therefore, that the House defer any action on this resolution.

Mr. President, I move for the adoption of this portion of the report.

(Motion seconded, put to vote, and carried.)

Mr. President, I move for the adoption of this report as a whole.

(Motion seconded, put to vote, and carried.)

I certainly want to thank the members of the reference committee, Drs. Thomas, Santare, Stouder and Orr. Thank you very much.

INSURANCE

The following matters were referred to the Reference Committee on Insurance. All reports will be found on the pages indicated in the September, 1966, Vol. 59, *Journal of the Indiana State Medical Association*, with the exception of the remarks of the president of Blue Shield, which are printed below, and the annual report of the president of Blue Shield, copy of which was handed to each delegate. Resolutions introduced before the House and referred to this committee are printed herewith.

Commission on Medical Economics and Insurance (pages 1070-71)

Report of Glen V. Ryan, M.D., president of Blue Shield (handed to each delegate)

Resolution No. 8 — CHANGE IN PL 89-97

Resolution No. 11 — INVESTIGATION OF PL 89-97

Resolution No. 16 — LIMITING BLUE SHIELD BOARD MEMBERSHIP

Resolution No. 22 — CERTIFICATION FOR MEDICARE PATIENTS

Resolution No. 23 — HEALTH INSUR-

ANCE

Resolution No. 24 — MUTUAL MEDICAL INSURANCE, INC.

Resolution No. 30 — THE ETHICS OF INDIVIDUAL RESPONSIBILITY

REFERENCE COMMITTEE ACTION

Dr. Malcolm O. Scamahorn, chairman, presented the following report:

The following matters were referred to the Reference Committee on Insurance:

1. *Report of Commission on Medical Economics and Insurance.* We recommend that the commission's report be amended as follows: At the end of the first full paragraph on page 112 of your Handbook add the following:

"If Continental Casualty does not show evidence of 1,600 accepted applicants by April 1, 1967, the ISMA support is automatically terminated and the group disability program is to be discontinued."

Mr. President, I move the adoption of this amendment.

(Motion seconded, put to vote, and carried.)

Also on page 112, the third paragraph, line 11, after the word "delayed" the following words to be added: "The reference committee recommends that the House of Delegates remove the words 'approved carrier for ISMA' from any advertising or statements by St. Paul Mercury Indemnity Company." This is only to remove any special approval that this company may enjoy.

Mr. President, I move the adoption of this section.

(Motion seconded, put to vote, and carried.)

We recommend and commend the Commission on Medical Economics for this report.

Report of President of Blue Shield

DR. GLEN V. RYAN, president of Blue Shield, addressed the House as follows: Mr. President, officers, delegates: Again it is an honor and privilege for me to appear before you as president of Blue Shield. You have before you, I am sure, our printed report; it speaks for itself.

A great many things have happened to the medical profession and Blue Shield since I reported to you one year ago. Blue Shield has found it necessary to adjust to a fast changing world. We have always been challenged with the changing practice of medicine and have adapted to it. I think I can accurately say, however, that there have been more changes, more problems; yes, more challenges this past year than in all of the other 19 years combined. Let me compare the picture of September, 1965, with what we see in September of 1966.

Our regular claims volume has shown an increase of 15%. This has come about in the face of a predicted decline since our over age 65 members are now a part of the Medicare program. We have been faced with new demands for coverage in previously uncharted areas from our large buyers. For example: new psychiatric benefits both on an out-patient and in-patient basis for General Motors, Ford, and Chrysler employees and prenatal, delivery, and postnatal care (the whole package), in the field of obstetrics for the same group. In September we received approximately 20,000 claims from Medicare beneficiaries. Our administration of the Medicare program has made drastic changes in our total organization.

Our total number of employees has doubled since last year. This means growing pains and the training of young neophytes inexperienced in claim processing. Medicare administration also means dealing with government laws and regulations which sometimes just do not seem logical to a free private enterprise operation.

But even amidst all these problems, including the attempt on the part of Blue Shield to adjust to the changing methods of billing from the radiologist and pathologist in addition to the problem I have just outlined, claim processing time is still approximately eight working days on our regular business and 15 working days for Medicare.

Incidently, I am sure that you will be interested to know that 95% of those Medicare payments represent payment in full of the doctor's charge according to our latest survey.

This record has not been an easy accomplishment, believe me, and has been the result of a six-day work week for the last few months on the part of our loyal and conscientious employees. Probably not in the past 20 years has the need for an even closer relationship and 2-way communication between Blue Shield and the ISMA been so apparent. This was brought out very clearly a few minutes ago by Dr. Rifner.

I believe my feeling and that of the other 18 physicians, who serve our members *and* the medical profession, on the Blue Shield Board of Directors can really be summarized by a statement made by Dr. Norman A. Welch, former President of the AMA just shortly before his untimely death when he said, and I quote, "Doctors who participate in Blue Shield do more to preserve the private practice of medicine than by any other single effort."

REFERENCE COMMITTEE ACTION

Dr. Malcolm O. Scamahorn, chairman, presented the following report:

2. *Report of President of Blue Shield.* Regarding the report of the president of Blue Shield, we recommend that it be filed and that the president of Blue Shield, Dr. Glen Ryan, be commended.

Mr. President, I move the adoption of this section of the report.

(Motion seconded, put to vote and carried.)

Resolution No. 8

Introduced by: VANDERBURGH COUNTY MEDICAL SOCIETY

Subject: CHANGE IN PL 89-97

WHEREAS, the Medicare program of payment for professional services by physicians provides, as an alternative to assignment of benefits, that a *receipted* bill can be utilized by a beneficiary to collect his reimbursable portion, and

WHEREAS, the necessity of first raising the full amount in cash may entail a very real hardship for many such patients, and this, in turn, unjustly generates criticism largely directed toward the physician, who did not devise this arrangement,

NOW THEREFORE BE IT RESOLVED, that ISMA directs its officers to attempt to persuade the responsible government agencies to change the mechanics of reimbursement for professional services under Medicare so that a valid statement for professional service rendered may be utilized to obtain the payment, with appropriate measures to prevent abuses, and

BE IT FURTHER RESOLVED, that our delegates to AMA work toward similar efforts by the American Medical Association.

REFERENCE COMMITTEE ACTION

Dr. Malcolm O. Scamahorn, chairman, presented the following report:

3. *Resolution No.* 8—CHANGE IN PL 89-97. Mr. President, the committee approves Resolution No. 8 and recommends its adoption, and I do so move.

(Motion seconded, put to vote, and carried.)

Resolution No. 11

Introduced by: FORT WAYNE (ALLEN COUNTY) MEDICAL SOCIETY

Subject: INVESTIGATION OF PL 89-97

WHEREAS, it is the opinion of many that Public Law 89-97 changes the social and political relationships of the Federal Government to the states of the Union and the citizens thereof in a manner both illegal and unconstitutional,

NOW THEREFORE BE IT RESOLVED,

that the Indiana State Medical Association shall employ a firm of attorneys well versed in constitutional law to investigate these aspects of the law, and if in their opinion Public Law 89-97 is indeed unconstitutional, that these attorneys shall be instructed to take whatever steps may be necessary in order to have this law declared null and void, either through their own direct actions or in association with the legal counsel of the American Medical Association.

REFERENCE COMMITTEE ACTION

Dr. Malcolm O. Scamahorn, chairman, presented the following report:

4. *Resolution No.* 11—INVESTIGATION OF PL 89-97. Regarding Resolution No. 11, with the approval of the county society introducing the resolution, it was withdrawn.

Resolution No. 16

Introduced by: THE COUNCIL
Subject: LIMITING BLUE SHIELD BOARD MEMBERSHIP

WHEREAS, the Indiana State Medical Association has for some time limited the tenure of office of members of the Council and of the commissions and committees to two successive terms, and

WHEREAS, within the membership of the association are many with diversified talents who should be encouraged to put them to use, and

WHEREAS, the many and varied problems facing us today may demand new and fresh approaches,

NOW THEREFORE BE IT RESOLVED, that the terms of the Directors of Mutual Medical Insurance, otherwise known as Blue Shield, be limited to no more than three successive full terms under stipulations comparable to those set forth in Chapter VIII, Section 5, of the ISMA bylaws, and

BE IT FURTHER RESOLVED, that suitable resolutions be prepared for enactment by the House of Delegates at its next meeting to effect these changes.

REFERENCE COMMITTEE ACTION

Dr. Malcolm O. Scamahorn, chairman, presented the following report:

5. *Resolution No.* 16—LIMITING BLUE SHIELD BOARD MEMBERSHIP. Mr. President, this committee approves Resolution No. 16 and recommends its adoption, and I so move.

(Motion seconded, put to vote, and carried.)

Resolution No. 22

Introduced by: DELAWARE-BLACKFORD COUNTY MEDICAL SOCIETY
Subject: CERTIFICATION FOR MEDICARE PATIENTS

WHEREAS, Section 1801, Title XVIII, of Public Law 89-97 clearly states, "nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, ...; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person," and,

WHEREAS, various officials of the Department of Health, Education and Welfare have been ambiguous and evasive in their interpretation as to what constitutes certification and recertification of medicare patients, and,

WHEREAS, Indiana Blue Cross, acting as an agent of the government, interpreted this action of the Department of Health, Education and Welfare as requiring that certification and recertification contain the words "Medically Necessary" and has so advised its participating hospitals, and,

WHEREAS, various Indiana hospitals have adopted by administrative action, a specific certification form and are compelling members of their clinical staffs to sign this form for medicare patients upon threat of loss of admitting privileges for all patients, and,

WHEREAS, such requirements of certification and recertification of "Medical Necessity" for hospitalization of medicare patients does deviate from the ordinary procedure followed in providing hospital care to all patients, and,

WHEREAS, compliance by staff physicians with such a requirement would establish the precedence of Federal bureaucratic control over the individual practice of medicine, set the medicare patient apart from regular patients in their admission procedure for hospitalization, and have the effect of forcing physicians to participate in medicare against their will, and,

WHEREAS, all hospitals and health insurance carriers including Indiana Blue Cross have always accepted an admitting diagnosis, adequate history and physical examination, and periodic progress notes as proper documentation for need of hospitalization, and,

WHEREAS, it is the desire of the members of the Indiana State Medical Association to continue to serve all patients in need of hospital medical care in the usual and customary manner regardless of whether such patients are medicare recipients,

NOW THEREFORE BE IT RESOLVED, that the Indiana State Medical Association advise its members to continue to support ethical and quality medical care for all patients and advises its members to refuse to sign special certification and recertification forms or execute special statements of "Medical Necessity" for hospitalization of medicare recipients, and,

BE IT FURTHER RESOLVED, that the Indiana State Medical Association condemn Indiana Blue Cross and the various hospitals that have required special certification and recertification forms or statements of "Medical Necessity" and demand that Indiana Blue Cross and the various hospitals accept the usual method of hospitalization for all patients, and,

BE IT FURTHER RESOLVED, that the Indiana State Medical Association instruct its delegates to the American Medical Association to present a similar resolution to the House of Delegates of the American Medical Association at its next session and secure its passage therein.

REFERENCE COMMITTEE ACTION

Dr. Malcolm O. Scamahorn, chairman, presented the following report:

6. *Resolution No.* 22—CERTIFICATION FOR MEDICARE PATIENTS. Regarding Resolution No. 22, the committee recommends that the second paragraph on the second page be amended as follows: After the word "patients" add the words "and recording of same."

Mr. President, I move the adoption of this amendment to the resolution.

(Motion seconded, put to vote, and carried.)

Mr. President, the committee now approves Resolution No. 22 as amended and recommends its adoption, and I so move.

(Motion seconded, put to vote, and carried.)

Resolution No. 23

Introduced by: THE COUNCIL
Subject: HEALTH INSURANCE

WHEREAS, several insurance companies require inpatient status in order to cover diagnosis and other services, and

WHEREAS, such requirement utilizes hospital beds unnecessarily since many such services can be done on an outpatient basis,

NOW THEREFORE BE IT RESOLVED, that the Indiana State Medical Association strongly recommends to the insurance carriers in the state that the inpatient status requirement be discontinued for these services in order to free as many hospital beds as possible so they may be utilized by patients with a definite medical need.

REFERENCE COMMITTEE ACTION

Dr. Malcolm O. Scamahorn, chairman, presented the following report:

7. *Resolution No.* 23—HEALTH INSURANCE. Mr. President, the committee approves Resolution No. 23 and recommends its adoption, and I so move.

(Motion seconded, put to vote, and carried.)

Resolution No. 24

Introduced by: SHELBY COUNTY MEDICAL SOCIETY

Subject: MUTUAL MEDICAL INSURANCE, INC.

WHEREAS, the original purpose of the House of Delegates of Indiana State Medical Association when organizing the Mutual Medical Insurance, Inc., was to:

1. Forestall the socialized medicine threat of that year, and,
2. Provide the insurance industry with the needed statistical experience to entice private enterprise into the prepaid medical field, and,

WHEREAS, the original needs no longer exist and that prepaid medical insurance field is both competitive and adequate, and a form of socialized medicine is now the law of the land, and,

WHEREAS, Mutual Medical Insurance, Inc. has repeatedly "spoken for organized medicine" in a voice contrary to the desires and interest of the practicing physician. Mutual Medical Insurance, Inc. has

1. Negotiated a contract with auto and steel without authorization of Indiana State Medical Association and then attempted to force the fixed fee schedule upon a special meeting of this House of Delegates, and,
2. To all practical purposes, all but forced all policy holders over 65 to accept the Medicare program by its arbitrary cancellation of existing policies, and,
3. Has contributed to the Hartford City and Madison County problems of "medical necessity", and,
4. Delayed claims as much as 60 to 90 days by arbitrarily invoking the "duplicate coverage principal" and thus creating much resulting confusion to the policy holders as well as the medical profession, and,
5. Arbitrarily entered into a contract with the Indiana Welfare Department in direct conflict with the Indiana State Medical Association policy concerning the "assignment" principal and the avowed interest of the practicing physician, and,

WHEREAS, the principle of Mutual Medical Insurance, Inc. "speaking for the medical profession" has in the past precipitated public relations conflicts in basic medical philosophy and policy and that any potential continuation of this is totally unacceptable, and,

WHEREAS, it is the avowed will of the practicing physician that only the Indiana Medical Association will speak for the profession.

NOW THEREFORE BE IT RESOLVED, that this House of Delegates instruct the physician members of the board of Mutual Medical Insurance, Inc. to take immediate steps to dissolve the Mutual Medical Insurance, Inc. in the most expeditious manner possible. The basic intent of this action being to return this segment of the prepaid medical insurance industry to private enterprise. To guarantee this action, this House asks that each physician board member of Mutual Medical Insurance, Inc., declare his intentions concerning the problem, and if not willing to follow the intent of this House, that he be removed from board membership by vote of this House and be replaced by a representative of this House of Delegates who will follow the will of the House, and,

BE IT FURTHER RESOLVED, that this resolution be presented to the Council for action and recommendation to the House of Delegates in order to avoid any premature publicity release that would embarrass the profession and Indiana State Medical Association.

REFERENCE COMMITTEE ACTION

Dr. Malcolm O. Scamahorn, chairman, presented the following report:

8. *Resolution No.* 24—MUTUAL MEDICAL INSURANCE, INC. The reference committee disapproves Resolution No. 24 as written and recommends its rejection and adoption of the following substitute resolution.

"BE IT RESOLVED, that in view of the local, state and national policy of physicians not taking assignments it is most traumatic for the physicians of this state to realize that the Public Welfare Department and Mutual Medical Insurance, Inc., have entered into a contract which requires the physician to take an assignment. If the present discussion with the attorney general, attorneys of Mutual Medical Insurance, and the attorneys of ISMA does not remove the necessity of taking assignments, it is the opinion of this committee that the House of Delegates should go on record opposing the renewal of the present contract between the Public Welfare Department and Mutual Medical Insurance, Inc. The renewal notice date of the present contract is April 1, 1967.

Furthermore, this committee recommends that the Council of the ISMA and the board members of Mutual Medical Insurance, Inc. join together in every proposed action of mutual interest concerning policy made by Mutual Medical Insurance, Inc.

Mr. President, I now move the adoption of this substitute resolution.

(Motion seconded.)

Dr. Mouser, Marion County, suggested the following two editorial changes, which were accepted by the House:

(1) That the word "suggested" be inserted in the first sentence of the RESOLVE before the word "local", and

(2) That the word "present" be deleted in the second sentence in the RESOLVE and "discussion" be changed to "discussions."

The resolution was discussed by Drs. Kintner, Black, Owsley, Glock, Steen, Dalton and Scamahorn.

Dr. Scamahorn then moved that the following amendment be inserted preceding the last sentence in the RESOLVE which reads, "The renewal notice date of the present contract is

"Furthermore, the House of Delegates disapproves any other contract as long as that contract requires payment by assignment. The Council shall observe and implement this wish until the next meeting of the House of Delegates."

(Motion seconded, discussed further by Dr. McClure, put to vote, and adopted.)

Dr. Scamahorn then read the resolution, as amended:

"BE IT RESOLVED, that in view of the suggested local, state and national policy of physicians not taking assignments it is most traumatic for the physicians of this state to realize that the Public Welfare Department and Mutual Medical Insurance, Inc., have entered into a contract which requires the physician to take an assignment. If the discussions with the attorney general, attorneys of Mutual Medical Insurance, and the attorneys of ISMA do not remove the necessity of taking assignments, it is the opinion of this committee that the House of Delegates should go on record opposing the renewal of the present contract between the Public Welfare Department and Mutual Medical Insurance, Inc. Furthermore, the House of Delegates disapproves any other contract as long as that contract requires payment by assignment. The Council shall observe and implement this wish until the next meeting of the House of Delegates. The renewal notice date of the present contract is April 1, 1967.

"Furthermore, this committee recommends that the Council of the ISMA and the board members of Mutual Medical Insurance, Inc. join together in every proposed action of mutual interest concerning policy made by Mutual Medical Insurance, Inc."

Mr. President, I now move the adoption of this substitute resolution.

(Motion seconded, and adopted on voice vote.)

Resolution No. 30

Introduced by: MADISON COUNTY MEDICAL SOCIETY

Subject: THE ETHICS OF INDIVIDUAL RESPONSIBILITY

WHEREAS, quality medical care can only be assured by maintaining the fundamental principles of the patient-physician relationship free from the influence of third parties, and,

WHEREAS, this is embodied in the principles of medical ethics of the American Medical Association, Section VI, which reads "A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care," and,

WHEREAS, this is embodied in the principles of individual responsibility wherein the physician is responsible to the patient for all aspects of rendering medical care to the best of his ability; and the obtaining and providing for the payment of medical care are the primary responsibilities of the individual citizen, and,

WHEREAS, the acceptance of benefits from a fiscal intermediary has posed in the past, and will continue to pose, a distinct threat to this patient-physician relationship and can result in deterioration of quality medical care, and,

WHEREAS, the attending physician's statement of individual responsibilities is reasonable and adequate for reports of medical services to patients for reimbursements and serves as a "direct billing" mechanism; thus eliminating third party interference in the "doctor-patient" relationship,

NOW THEREFORE BE IT RESOLVED, that the House of Delegates of the Indiana State Medical Association, October 12, 1966, endorses and approves the ethics and the principle of individual responsibility in the distribution of medical services by physicians, and,

BE IT FURTHER RESOLVED, that the principle of individual responsibility is well sustained by an adequate statement or report by the attending physician, recognized as an ethical means for use by those physicians who voluntarily desire and decide to use it, and,

BE IT FURTHER RESOLVED, that all members of the Indiana State Medical Association be informed by the Board of Councilors of the Indiana State Medical Association of this action with supporting information in order that physicians may voluntarily preserve an ethical patient-physician relationship, and,

BE IT FURTHER RESOLVED, that the House of Delegates of the Indiana State Medical Association request its delegation to the American Medical Association to introduce and support this resolution at the next meeting of the House of Delegates of the American Medical Association.

REFERENCE COMMITTEE ACTION

Dr. Malcolm O. Scamahorn, chairman, presented the following report:

9. *Resolution No.* 30—ETHICS OF INDIVIDUAL RESPONSIBILITY. Mr. President, this committee approves this resolution and recommends its adoption and, if adopted, charges the Commission on Medical Economics and Insurance to work with the interested insurance companies to implement an acceptable form for all concerned. Mr. President, I move the acceptance of this approval.

(Motion seconded by many, discussed by Dr. Owsley, put to vote, and carried.)

Mr. President, I urge the adoption of this report as a whole, as amended.

(Motion seconded, put to vote, and carried.)

I wish to thank all of you who appeared before the reference committee.

MISCELLANEOUS BUSINESS

The following matters were referred to the Reference Committee on Miscellaneous Business. All reports will be found on the pages indicated in the September, 1966, Vol. 59, *Journal of the Indiana State Medical Association.* Resolutions introduced before the House and referred to this committee are printed herewith.

Committee on Student Loan (page 1062)

Commission on Convention Arrangements (no printed report)

Building Committee (pages 1062-63)

Commission on Governmental Medical Services (pages 1066-67)

Resolution No. 4—AMA SUPPORT OF THE COLLEGE OF AMERICAN PATHOLOGISTS

Resolution No. 5—CORRECTION OF PRACTICE OF JOINT COMMISSION ON ACCREDITATION OF HOSPITALS OF CERTIFYING HOSPITALS WHICH HAVE NON-PHYSICIAN LABORATORY DIRECTORS

Resolution No. 28—NEED FOR ADOPTION OF A NATIONAL STATEMENT OF POLICY REGARDING HOSPITAL-PHYSICIAN RELATIONS

REFERENCE COMMITTEE ACTION

Dr. Philip J. Rosenbloom, chairman, presented the following report:

The report as taken up by the committee dealt with Resolution No. 4, Resolution No. 5, and Resolution No. 28, and also two reports, on Student Loan Committee, and that of the Building Committee, the latter two being printed in the Handbook on pages 98 and 99.

1. *Report of Student Loan Committee.* This was carefully reviewed, the chairman was interrogated on some of the items, and we feel that this committee has done extremely well in the process of handling funds and collecting the same. We commend this body for a job well done.

Mr. Chairman, I move the adoption of this portion of the report.

(Motion seconded, put to vote, and carried.)

2. *Convention Arrangements.* There was no written report on Convention Arrangements, but the reference committee feels that under the conditions the scientific program and the scientific exhibits were well exhibited, and brought many favorable comments from the delegates who have talked to the reference committee.

Mr. Chairman, I move the adoption of this portion of the report.

(Motion seconded, put to vote, and carried.)

3. *Report of the Building Committee.* After a thorough perusal of this report, the reference committee must comment on the sage business judgment of the chairman and his committee in building our home when they did, and in the acquisition of the extra land for future expansion. We appreciate the activity of the Woman's Auxiliary and the contribution which they have made to our comfort. We commend the committee for its ever vigilant activities, and we all await the final payment on the building, when we can truly call our home our own.

Mr. Chairman, I move the adoption of this report.

(Motion seconded, put to vote, and carried.)

4. *Report on Governmental Medical Services.* This was examined carefully, and with the multifarious services which our government offers and enters into, we feel that the committee has done a monumental work in keeping up with the varying programs, and we wish them well with the Fee Schedules, Title XIX, and the Medicare law. We commend them for a job well done.

Mr. Chairman, I move the adoption of this portion of the report.

(Motion seconded.)

Dr. Glen Lee offered the following correction to the report of the Commission on Governmental Medical Services, printed on page 106 of the Handbook: "Dr. J. R. Gambill has been named acting commissioner (to replace Dr. Ginsberg) until a new commissioner is appointed." This was accepted as an editorial change.

(Dr. Rosenbloom's motion for adoption of the report, as amended, was put to vote, and carried.)

Resolution No. 4

Introduced by: THE MARION COUNTY MEDICAL SOCIETY

Subject: AMA SUPPORT OF THE COLLEGE OF AMERICAN PATHOLOGISTS

WHEREAS, the Department of Justice has recently filed a suit at law against the College of American Pathologists, and

WHEREAS, the points at issue involve the ethics of all physicians, and

WHEREAS, this appears to be the beginning of harassment of the entire medical profession,

NOW THEREFORE BE IT RESOLVED, that the officers and delegates of the Indiana State Medical Association be requested to present a suitable resolution to the House of Delegates of the American Medical Association requesting the American Medical Association to give the College of American Pathologists support in every appropriate way.

REFERENCE COMMITTEE ACTION

Dr. Philip J. Rosenbloom, chairman, presented the following report:

5. *Resolution No.* 4—AMA SUPPORT OF THE COLLEGE OF AMERICAN PATHOLOGISTS. Inasmuch as pathology is an integral part of the practice of medicine, we support wholeheartedly this resolution and feel that it should be taken up by the Council, so that a suitable resolution can be presented to the AMA at its next convention.

Mr. Chairman, I move the adoption of this portion of the report.

(Motion seconded, put to vote, and carried.)

Resolution No. 5

Introduced by: THE MARION COUNTY MEDICAL SOCIETY

Subject: CORRECTION OF THE PRACTICE OF THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS OF CERTIFYING HOSPITALS WHICH HAVE NON-PHYSICIAN LABORATORY DIRECTORS

WHEREAS, approval of a hospital by the Joint Commission on Accreditation of Hospitals has become a mark of prestige, and

WHEREAS, the American Medical Association supports Joint Commission on Accreditation of Hospitals with finances and manpower, and

WHEREAS, the Joint Commission on Accreditation of Hospitals recently has certified hospitals which have laboratory directors who are not physicians, and

WHEREAS, the Indiana State Medical Association and the American Medical Association repeatedly have recognized the practice of clinical pathology as the practice of medicine,

NOW THEREFORE BE IT RESOLVED, that the officers and delegates of the Indiana State Medical Association be requested to present a suitable resolution to the House of Delegates of the American Medical Association seeking to correct this practice.

REFERENCE COMMITTEE ACTION

Dr. Philip J. Rosenbloom, chairman, presented the following report:

6. *Resolution No.* 5—CORRECTION OF THE PRACTICE OF THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS OF CERTIFYING HOSPITALS WHICH HAVE NON-PHYSICIAN LABORATORY DIRECTORS. We heartily support the fact that all laboratories or other facilities that use medical direction should be under the direction of a physician and we suggest that the Joint Accreditation Committee recognize that these branches of the profession are truly a part of medicine and should be only under the direction of those who have a knowledgeable training in directing such a laboratory.

Mr. Chairman, I move the adoption of this portion of the report.

(Motion seconded, put to vote, and carried.)

Resolution No. 28

Introduced by: MARION COUNTY MEDICAL SOCIETY

Subject: NEED FOR ADOPTION OF A NATIONAL STATEMENT OF POLICY REGARDING HOSPITAL-PHYSICIAN RELATIONS

WHEREAS, there is need for the adoption of a national statement of policy regarding hospital-physician relations by the American Medical Association,

NOW THEREFORE BE IT RESOLVED, that the Indiana delegation is hereby directed to introduce and support effectively the following resolution at the 1966 Clinical Convention of the American Medical Association in Las Vegas, Nevada:

WHEREAS, there is need for the American Medical Association to state its current policy position regarding hospital-physician relations, and,

WHEREAS, Title XVIII of the Social Security Act recognizes the principle of the separation of professional and hospital costs for services rendered by hospital-based physicians, and,

WHEREAS, this principle has been advocated by the American Medical Association, the American College of Radiology, the College of American Pathologists, and many regional organizations, and,

WHEREAS, it is detrimental to the public interest and the medical profession when the services of hospital-based physicians are provided at a financial profit to the hospital, and,

WHEREAS, it is necessary in the interest of the public and the medical profession that the services of all physicians, including hospital-based physicians, be clearly delineated, charged, and paid for as professional services,

NOW THEREFORE BE IT RESOLVED, that the American Medical Association hereby adopts the following statements of policy as its position with respect to hospital-physician relations:

1. Physicians and hospital authorities have the mutual responsibility to cooperate and work together effectively toward the constant goal of improving patient care and providing such care efficiently and at reasonable cost to the public.

2. Although final legal authority for granting, denying, terminating, or limiting hospital privileges may be vested in the governing board of the hospital, it is expected and necessary in the public interest that the governing board accept the determinations and judgment of the organized medical staff in the evaluation of professional competence, education, experience, ethical standards, and qualifications of all physicians, including hospital-based medical specialists.

3. In order to assure patients the services of professionally qualified ethical physicians, the contractual arrangements between hospital-based medical specialists should be subject to the condition that such physicians shall be admitted to the organized medical staff and retain membership in good standing in accordance with the same rules and procedures which apply to other members of the organized medical staff.

4. Hospital-based medical specialists are entitled to reasonable charges for their services. Hospitals are entitled to recover their costs, determined in accordance with recognized cost accounting principles, from the operation of departments in which hospital-based medical specialists perform their services. The addition of a profit to such costs by the hospital results directly or indirectly in increases in the cost of medical services and is opposed as detrimental to the public interest and the medical profession.

5. Constituent and component medical societies have a clear mandate to use every legally acceptable means to promote ethical contractual and separate billing arrangements between hospital-based physicians and hospitals in order that the services of these physicians may be provided to patients at reasonable charges and without inflation through the addition of hidden profits for the hospital, and in order that the independence and professional integrity of the medical profession may be preserved.

6. It is unethical for a physician to enter into any salaried or other contractual arrangement whereby a hospital engages in the

illegal corporate practice of medicine.

REFERENCE COMMITTEE ACTION

Dr. Philip J. Rosenbloom, chairman, presented the following report:

7. *Resolution No.* 28—NEED FOR ADOPTION OF A NATIONAL STATEMENT OF POLICY REGARDING HOSPITAL PHYSICIAN RELATIONS. The committee had a long deliberation on this resolution, with a great deal of pro and con comments from innumerable delegates and others, including our officials on this particular resolution.

We feel that this resolution is also not very well put together, and the committee feels that we may only open ourselves up to considerably more criticism, if not even legal action, by adopting this particular resolution.

We cannot abandon our former policies, but at the same time we must not substitute something that will make the notorious Resolution No. 104 even more involved, and lead us into more troubles.

The committee feels that these resolutions can lead to many misinterpretations, and therefore they should be carefully drawn up by our best brains, with all the legal aid possible which we can procure, so that we may not be spending much of our time defending ourselves from our avaricious enemies.

Mr. Chairman, I move that this Resolution No. 28 be not adopted.

(Motion seconded, put to vote, and carried.)

Now, Mr. Chairman, I move the adoption of the report of this reference committee as a whole.

(Motion seconded, put to vote, and carried.)

I want to thank the members of my committee, Max Hoffman of Covington, Fred Smith of Tell City and Lou Sandock of South Bend, and those who appeared before the committee.

ELECTION OF OFFICERS

The following officers were elected:

President-elect—G. O. Larson, M.D., LaPorte

Treasurer—Ottis N. Olvey, M.D., Indianapolis

Assistant Treasurer—Lester H. Hoyt, M.D., Indianapolis

AMA delegates and alternates for term expiring December 31, 1968:

Delegates:

Harold C. Ochsner, M.D., Indianapolis
Eugene F. Senseny, M.D., Fort Wayne
Frank H. Green, M.D., Rushville

Alternates:

James H. Gosman, M.D., Indianapolis
Robert M. Brown, M.D., Marion
Kenneth O. Neumann, M.D., Lafayette

ADDRESS OF PRESIDENT-ELECT

Mr. President, members of the House of Delegates: Would that I possessed the ability of an orator to better express to you the love which I have for the Indiana State Medical Association, and the great pride which I feel in being one of its members. Yet this same love and this pride almost make me tremble with humility when I think of the responsibilities which go along with a high office in this association. To every member of the Indiana State Medical Association I pledge to give the best that there is in me and to you, Gene, my personal loyalty as well.

Places of Future Annual Conventions

Dates and places previously set:

1967—Indianapolis, October 10, 11 and 12
1968—Fort Wayne, week of October 14
1969—Indianapolis
1970—Evansville
1971—Indianapolis

On motion of Dr. Lybrook, seconded by many, the invitation of Marion County to hold the 1971 annual convention in Indianapolis was accepted.

Oath of Office

Dr. Neumann turned the gavel over to Dr. Rifner, president 1966-67, who administered the oath of office, in accordance with Chapter V, Section 5, of the Bylaws, to all newly-elected officers, councilors and alternate councilors, as follows:

G. O. Larson, president-elect; Ottis N. Olvey, treasurer; Lester H. Hoyt, assistant treasurer; Councilors—Joe Dukes, Second District; Wilbert McIntosh, Fifth District; Donald R. Taylor, Eighth District; Lowell J. Hillis, Eleventh District; alternate councilor—James A. Harshman, Eleventh District.

Resolutions of Appreciation

Dr. Peter R. Petrich presented the following resolution which was adopted unanimously on a standing vote:

Appreciation of President

WHEREAS, the Indiana State Medical Association and its membership has experienced a year of unusual impact upon the profession as a whole, and,

WHEREAS, this impact has been the result of legislation at the Federal level, which has caused deep concern by the profession toward its implications in patient care and the free practice of medicine, and,

WHEREAS, throughout this period the association has been fortunate in having at its helm a leader, who in this critical period, has guided the policies of the association judiciously and with conviction, and,

WHEREAS, this year has imposed upon him extra burdens of time, travel, conscientious effort, and communication with the membership, and,

WHEREAS, this physician has met this obligation with unselfish devotion and dedication,

NOW THEREFORE BE IT RESOLVED, that this House of Delegates, through this resolution, thank Dr. Kenneth O. Neumann for his efforts on behalf of the membership and convey to him its gratitude for the many sacrifices to his family and personal life, and for a job well done.

Dr. Donald M. Kerr presented the following resolution which was adopted unanimously:

Appreciation of Commission on Convention Arrangements

WHEREAS, the program of this 117th annual convention has been an exceptionally fine one, and,

WHEREAS, it is well known that the development of such a program is time-consuming to the members of the committee who have met many times and formulated plans for the excellent scientific sessions months in advance, and,

WHEREAS, the entertainment and tournament features have been extraordinarily pleasant and relaxing, and,

WHEREAS, this has all been accomplished through the efforts of the Commission on Convention Arrangements under the chairmanship of Dr. Francis E. Stout of Muncie,

NOW THEREFORE BE IT RESOLVED, that the Indiana State Medical Association extend to this commission, to the members of the Woman's Auxiliary, to the Indiana Chapter, American Academy of Pediatrics, and to the Indiana Chapter of the American College of Chest Physicians their sincere thanks for excellent planning and execution.

Adjournment

The House of Delegates adjourned, *sine die*, at 1:00 p.m., Thursday, October 13, 1966.

ROLL CALL VOTES ON AMENDMENTS TO ISMA CONSTITUTION AND BYLAWS

(D) Delegate
(A) Alternate
A = Aye
N = Nay
NV = Not voting or absent

COUNTY	DELEGATE	Three Amendments to Constitution Voted on 10/10/66	Amendment to the Bylaws Voted on 10/13/66
ADAMS			
ALLEN	W. L. Bridges (D)	A	A
	J. L. Andrew (D)	A	A
	E. D. Miller (D)	A	A
	J. S. Farquhar (D)	A	A
	R. B. Juergens (D)	A	N
	Charles H. Aust (D)	A	A
BARTHOLOMEW-BROWN	Harold W. Richmond (D)	A	A
	Robert Seibel (D)	NV	NV
BENTON	Donald L. McKinney (D)	NV	A
BOONE	Clarence G. Kern (D)	A	NV
CARROLL	T. Neal Petry (D)	A	A
CASS	R. H. Maschmeyer (A)	A	NV
	Donald K. Winter (A)	NV	A
CLARK	Eli Goodman (D)	A	A
CLAY	Rahim Farid (D)	NV	NV
CLINTON	Robert A. Hedgcock (D)	A	A
DAVIESS-MARTIN	C. Philip Fox (D)	A	A
	E. B. Lett (D)	NV	NV
DEARBORN-OHIO	Leslie M. Baker (D)	A	A
	Gordon S. Fessler (D)	A	A
DECATUR	William Shaffer (D)	NV	NV
DE KALB	William B. Hughes (D)	A	A
DELAWARE-BLACKFORD	Thomas M. Brown (D)	A	A
	Ross L. Egger (A)	A	A
	Richard Ingram (A)	A	A
DUBOIS	Thomas Gootee (D)	A	NV
ELKHART	Edward G. Dovey (D)	A	A
	Burton E. Kintner (D)	A	A
FAYETTE-FRANKLIN	Wm. F. Kerrigan (D)	A	A
	H. N. Smith (D)	NV	NV
FLOYD	Irvin H. Sonne (D)	A	A
FOUNTAIN-WARREN	Max Hoffman (D)	A	A
	T. T. Suzuki (A)	NV	A
FULTON	Dean K. Stinson (D)	NV	NV
GIBSON	William E. Dye (D)	NV	A
GRANT	Robert M. Brown (D)	A	A
GREENE	Harry G. Rotman (D)	NV	NV
HAMILTON	Joe R. Lloyd (D)	NV	NV
HANCOCK	W. H. Endicott (D)	A	A
HARRISON-CRAWFORD	L. H. Blessinger (D)	A	A
	Jesse C. Benz (D)	A	NV
HENDRICKS	M. O. Scamahorn (D)	NV	A
HENRY	Kenneth G. Hill (D)	NV	NV
HOWARD	Warren M. McClure (D)	A	N
HUNTINGTON	Richard W. Wagner (D)	NV	NV
JACKSON-JENNINGS	Forrest Ellis (D)	NV	A
	Harry R. Baxter (D)	A	NV

(D) Delegate
(A) Alternate
A = Aye
N = Nay
NV = Not voting or absent

COUNTY	DELEGATE	Three Amendments to Constitution Voted on 10/10/66	Amendment to the Bylaws Voted on 10/13/66
JASPER	K. R. Ockermann (D)	NV	NV
JAY	James Fitzpatrick (D)	NV	A
JEFFERSON-SWITZERLAND	Robert O. Zink (D)	NV	NV
	Noel Graves (D)	NV	NV
JOHNSON	Joseph Young (D)	A	A
KNOX	H. O. Chattin (D)	A	A
KOSCIUSKO	William J. Cron (D)	A	A
LA GRANGE	Philip E. Yunker (D)	NV	NV
LAKE	Philip J. Rosenbloom (D)	NV	A
	W. A. Nelson (A)	NV	A
	Jacob Pruitt (D)	A	A
	C. T. Disney (A)	A	A
	T. C. Tyrrell (D)	A	A
	D. B. Templin (D)	NV	A
	V. J. Santare (D)	A	A
	C. O. Almquist (D)	A	A
LA PORTE	G. O. Larson (D)	A	A
	T. D. Armstrong (D)	A	A
LAWRENCE	J. C. Dusard (D)	A	A
MADISON	P. T. Lamey (D)	A	A
	R. D. Williams (D)	A	A
MARION	John O. Butler (D)	A	A
	William B. Lybrook (A)	NV	A
	Sprague H. Gardiner (D)	A	A
	David Hadley (D)	A	A
	F. R. Brueckmann (A)	A	NV
	Robert W. Mouser (A)	A	A
	Kenneth L. Gray (A)	A	A
	Morris E. Thomas (D)	A	A
	A. M. Donato (D)	NV	A
	J. H. Gosman (D)	A	A
	M. Richard Harding (A)	A	NV
	D. W. Schuster (D)	A	A
	D. E. Stephens (D)	A	NV
	J. L. Haymond (D)	A	A
	Jack W. Hickman (D)	A	A
	William A. Karsell (D)	A	A
	T. E. Lunsford (D)	NV	A
	Hunter A. Soper (D)	A	A
	Frank Albertson (D)	NV	A
	Charles E. Test (D)	A	A
	Harold Ochsner (A)	NV	A
MARSHALL	Robert Reed (D)	NV	NV
MIAMI	Lloyd Hill (D)	A	N
MONTGOMERY	R. R. Eggers (D)	A	A
MORGAN	Jay Reese (D)	A	N
NEWTON	R. S. Yegerlehner (D)	NV	NV
NOBLE	Robert Bryan (D)	NV	NV

(D) Delegate
(A) Alternate
A = Aye
N = Nay
NV = Not voting or absent

		Three Amendments to Constitution Voted on 10/10/66	Amendment to the Bylaws Voted on 10/13/66
COUNTY	DELEGATE		
ORANGE	P. T. Hodgin (D)	A	NV
OWEN-MONROE	J. A. Creek (D)	A	A
	Roger Roof (D)	NV	NV
PARKE-VERMILLION			
PERRY	Fred Smith (D)	A	A
PIKE	Milton H. Omstead (D)	NV	NV
PORTER	Jack E. Dittmer (D)	NV	NV
POSEY	L. John Vogel (D)	A	A
PULASKI	William R. Thompson (D)	NV	NV
PUTNAM	Fredrick Dettloff (D)	NV	NV
RANDOLPH	Lowell Painter (D)	A	A
RIPLEY	Bill Freeland (D)	A	NV
RUSH	Frank H. Green (D)	A	A
ST. JOSEPH	L. F. Sandock (D)	A	A
	W. Robert Orr (D)	A	A
	Raymond E. Nelson (D)	A	A
	J. Rosenwasser (D)	A	NV
	S. E. Bechtold (D)	NV	A
SCOTT	Marvin McClain (D)	A	NV
SHELBY	Wilson L. Dalton (D)	A	A
SPENCER	J. C. Glackman, Jr. (D)	A	A
STARKE	Guy B. Ingwell (D)	A	A
STEUBEN	D. G. Mason (D)	A	A
SULLIVAN	Betty Dukes (D)	A	A
TIPPECANOE	R. B. DuBois (D)	A	A
	F. J. Babb (D)	NV	A
TIPTON	A. E. Stouder (D)	A	A
VANDERBURGH	R. H. Burnikel (D)	A	A
	Albert Ritz (A)	A	A
	A. W. Ratcliffe (D)	A	A
	G. W. Willison (D)	A	A
	John D. Wilson (D)	A	NV
	Joseph C. Lawrence (A)	NV	A
VIGO	William G. Bannon (D)	A	NV
	Thomas J. Conway (D)	A	A
WABASH	F. C. Poehler (D)	NV	A
WARRICK	W. C. Stover (D)	A	A
WASHINGTON	T. K. Tower (D)	NV	NV
WAYNE-UNION	Glen Ward Lee (D)	A	A
	C. G. Clarkson (D)	NV	A
WELLS	T. E. Caylor (D)	A	A
WHITE	W. M. Dickerson (D)	A	A
WHITLEY	T. Hamilton (D)	A	NV
DISTRICT	COUNCILORS		
1st	P. J. V. Corcoran	A	A
2nd	E. T. Edwards	A	NV
3rd	Donald M. Kerr	A	A
4th	Robert M. Reid	NV	NV

(D) Delegate
(A) Alternate
A = Aye
N = Nay
NV = Not voting or absent

DISTRICT	COUNCILORS	Three Amendments to Constitution Voted on 10/10/66	Amendment to the Bylaws Voted on 10/13/66
5th	V. E. Wiseman	A	A
6th	William R. Tindall	A	A
7th	Albert M. Donato	NV	A
8th	Donald R. Taylor	A	A
9th	Peter R. Petrich	A	A
10th	Lowell H. Steen	A	A
11th	Lowell Hillis	A	A
12th	Milton F. Popp	NV	A
13th	Otis R. Bowen	A	A
	PAST-PRESIDENTS		
	Franklin S. Crockett		
	Herman M. Baker		
	Karl R. Ruddell		
	M. A. Austin		
	Paul D. Crimm		A
	W. Harry Howard		
	W. U. Kennedy		
	Elton R. Clarke		
	M. C. Topping	A	
	Kenneth L. Olson		
	Earl W. Mericle	A	
	Guy A. Owsley	A	A
	Maurice E. Glock	A	A
	Donald E. Wood	A	A
	Joseph M. Black	A	A

Association News

EXECUTIVE COMMITTEE

October 9, 1966

Meeting called to order at 6:00 p.m.

Present: Ralph V. Everly, M.D., chairman; G. O. Larson, M.D.; Kenneth O. Neumann, M.D.; Eugene S. Rifner, M.D.; E. T. Edwards, M.D.; Ottis N. Olvey, M.D.; Lester Hoyt, M.D.

Ralph Hamill, attorney, and James A. Waggener, executive secretary.

The remarks of the president, to be given at the first meeting of the House of Delegates, were approved on motion of Drs. Larson and Olvey.

Membership Report:

Number of members as of December 31, 1965		4,394
1966 members as of September 30, 1966:		
Full dues paying	3,857	
Residents and interns	116	
Council remitted	51	
Senior	310	
Honorary	3	
Military	37	
Total 1966 members as of September 30, 1966		4,374
Number of members as of September 30, 1965		4,370
Gain over last year		4
Number of AMA members as of September 30, 1966		4,259
Total 1965 AMA members as of September 30, 1965		4,267
Loss over last year		8
1966 AMA members:		
Dues paying	3,744	
Exempt, but active	515	
		4,259
Number who have paid state dues but not AMA dues as of September 30, 1966		115

Headquarters Office

The secretary reviewed the reply from Blue Cross concerning the group contract and upon motion of Drs. Neumann and Rifner, the secretary was instructed to renew the contract for the employees of the headquarters office.

Upon motion of Drs. Edwards and Olvey, the field men and Mr. Bush were authorized to attend the Las Vegas meeting of the AMA.

Upon motion of Drs. Neumann and Rifner, the secretary was instructed to send greetings to Dr. Olson.

Treasurer's Office

The treasurer's report was accepted by consent.

Annual Convention, French Lick, October 10, 11, 12 and 13, 1966

The secretary reported that the Commission on Public Information had contacted the county medical societies and had recommended that a public relations award be given to the *Greensburg News* and to TV station WTHI at Terre Haute. Since the commission had conformed to the rules as adopted by the House, these awards were approved.

Dr. Rifner commented that the Commission on Public Information should be advised to keep in mind the Marion, Indiana, radio station as a candidate for the 1967 award.

Resolution No. 32 concerning implementation of Title XIX was referred to the Council on motion of Drs. Rifner and Larson.

Resolution No. 23 concerning advising insurance carriers to remove the requirement of inpatient care for diagnostic and other services was referred to the Council upon motion of Drs. Larson and Edwards.

Legislation

Local: The secretary reviewed for the information of the committee the proposed bill to implement Title XIX in the state of Indiana, and also correspondence from Mr. Hollowell, addressed to Dr. Kirtley, outlining for inclusion in legislation a proposal to establish adjudication committees at the county society level.

A letter from the National Municipal League concerning the association taking an interest in developing a forensic science department was read and upon motion of Drs. Edwards and Rifner, this is to be referred to the Commission on Legislation with a recommendation that they attempt to reactivate this idea in Indiana.

Upon motion of Dr. Edwards and taken by consent, the Chamber of Commerce Legislative Reporting Service is to be sent to members of the Council, the Executive Committee, members of the Commission on Legislation and the headquarters office.

Organization Matters

A letter from the American Medical Association concerning vacancies on various councils and committees of the AMA was reviewed and recommendations for appointments were made, and the secretary was instructed to forward this information to the American Medical Association.

A letter was read from Dr. Offutt requesting a replacement on the Health Facilities Council for Dr. E. T. Edwards who had resigned. Upon motion of Drs. Edwards and Olvey, Dr. Lowell H. Steen was to be recommended to fill this vacancy.

A letter from Mr. T. Leonard Terry of the Mutual Life Insurance Company of New York concerning the association taking steps to approve a Medic Alert program for Indiana was read. By consent, the secretary was to check with the AMA on this organization and to report at the next meeting of the Executive Committee.

A letter from Mr. Bert Talbott, field representative of the National Foundation — March of Dimes, concerning distribution of a letter pointing out the services that are available at the Riley Hospital, was reviewed and on motion of Drs. Neumann and Larson, permission was granted to circularize such a letter on the letterhead of Indiana University School of Medicine.

A letter from Mr. Kingston G. Ely, requesting a statement to be read before the House of Delegates, was approved for reading and insertion in *The Journal*.

A letter from the Indiana State AFL-CIO seeking representatives of the association to discuss Medicare before its Regional Educational Conferences was discussed and by consent it was agreed to ask Dr. Wood to represent the association at the meeting to be held in Indianapolis on November 11, Dr. Larson to attend the meeting at Elkhart on November 18, and Dr. Corcoran to represent the association at the meeting in Tell City on December 2.

A letter from Dr. Schuster concerning proposing a legislative act to require people to designate their type of doctor degree was read for the information of the committee.

Medicare

The report of Mr. Hollowell giving his opinion on the interpretation of certification and recertification under PL 89-97 was distributed to the members of the committee for their information.

For the information of the committee a report was made concerning the activity of the association legal counsel and the legal counsel for Blue Cross-Blue Shield relative to the revision of the contract between Blue Shield and the State Department of Public Welfare.

A letter from Fred B. Wolf, regional representative of the Department of Health, Education and Welfare, was read for the information of the committee.

A letter from Mr. Hollowell proposing a form of note which might be used by physicians was reviewed and upon motion of Drs. Rifner and Edwards, this information is to be sent out only on request of the members of the county societies.

The question of Blue Shield including the payment for drugs under the welfare program was discussed and upon motion of Drs. Edwards and Rifner, this matter was referred to the Council.

Correspondence between Dr. Neumann and Mr. Kilborn of Blue Shield was reviewed for the information of the committee.

A suggested definition of "usual and customary" fees was reviewed for the information of the committee.

A report from the Medical and Chirurgical Faculty of the State of Maryland concerning

implementation of Title XIX was reviewed for the information of the committee.

New Business

For the information of the committee the president reported on the proposed visit of a Dr. Whitcomb of HEW, from Baltimore, at the Council meeting on Monday, October 10.

Future Meetings

Plans for the AMA meeting in Las Vegas were reviewed for the information of the committee.

Notice of the annual meeting of the Board of the Indiana State Chamber of Commerce at French Lick, October 13-15, 1966, was reviewed and by consent it was agreed that the association would bypass this meeting.

Notice of the meeting of executive secretaries in Des Moines, Iowa, October 26, 1966, was reviewed and it was agreed that the secretary should attend.

President-elect's Address

Upon motion of Drs. Larson and Edwards the remarks of President-elect Rifner were approved.

There being no further business the committee adjourned to meet again at the conclusion of the final meeting of the House of Delegates, on Thursday, October 13, 1966.

EXECUTIVE COMMITTEE

October 13, 1966

The Executive Committee convened following the close of the Council meeting, with the following members present:

Ralph V. Everly, M.D., chairman; Burton E. Kintner, M.D.; Eugene S. Rifner, M.D.; G. O. Larson, M.D.; Ottis N. Olvey, M.D.; Lester Hoyt, M.D., and Lowell H. Steen, M.D.

James A. Waggener, executive secretary.

Dr. Burton E. Kintner and Dr. Lowell H. Steen were welcomed as new members of the Executive Committee.

By secret ballot, Dr. Ralph V. Everly was elected chairman of the Executive Committee for the year 1966-1967.

There being no further business, the Executive Committee adjourned to meet again on October 30, 1966. ◄

THE COUNCIL

October 10, 1966

The Council convened at 8:00 a.m., Eastern Standard Time, Monday, October 10, 1966, in the Terrace Room of the French Lick-Sheraton Hotel, French Lick, Indiana, with Dr. E. T. Edwards, the chairman, presiding. Roll call showed the following present:

Councilors:

First District—P. J. V. Corcoran, Evansville
Gilbert M. Wilhelmus, Evansville, alternate
Second District—E. T. Edwards, Vincennes
Joe E. Dukes, Dugger, councilor-elect
Third District—Donald M. Kerr, Bedford
Fourth District—Robert M. Reid, Columbus
Jack E. Shields, Brownstown, alternate (also AMA delegate)
Fifth District—V. Earle Wiseman, Greencastle
A. W. Cavins, Terre Haute, alternate
Sixth District—William R. Tindall, Shelbyville
Frank H. Green, Rushville, alternate (also AMA alternate delegate)
Seventh District—Albert M. Donato, Indianapolis
John O. Butler, Indianapolis, alternate councilor-elect
Eighth District—Donald R. Taylor, Muncie
Paul W. Sparks, Winchester, alternate
Ninth District—Peter R. Petrich, Attica
Clarence G. Kern, Lebanon, alternate
Tenth District—Lowell H. Steen, Whiting
Herman Wing, Gary, alternate councilor-elect
Eleventh District—Lowell J. Hillis, Logansport
James A. Harshman, Kokomo, alternate councilor-elect
Twelfth District—William R. Clark, Fort Wayne, alternate
Thirteenth District—Otis R. Bowen, Bremen

Officers:

Kenneth O. Neumann, Lafayette, president
Eugene S. Rifner, Van Buren, president-elect
Ottis N. Olvey, Indianapolis, treasurer
Lester H. Hoyt, Indianapolis, assistant treasurer

Journal:

Frank B. Ramsey, Indianapolis, editor
Lall G. Montgomery, Muncie, associate editor

Executive Committee:

Ralph V. Everly, Indianapolis, chairman
G. O. Larson, LaPorte, member

Guests:

E. S. Jones, Hammond, AMA delegate
Guy A. Owsley, Hartford City, AMA delegate
James H. Gosman, Indianapolis, AMA alternate delegate
Robert M. Brown, Marion, AMA alternate delegate
Maurice E. Glock, Fort Wayne, AMA alternate delegate
Dwight W. Schuster, Indianapolis, AMA alternate delegate
Glenn W. Irwin, Jr., Indianapolis, dean, I.U. School of Medicine
A. C. Offutt, Indianapolis, State Health Commissioner
Lester D. Bibler, Indianapolis, AMA Trustee, and chairman, Student Loan Committee
Glen V. Ryan, Indianapolis, president, Mutual Medical Insurance, Inc.
Richard C. Kilborn, executive vice-president, Mutual Medical Insurance, Inc.

Staff:

Ralph Hamill, attorney
Robert J. Amick, field secretary
Howard Grindstaff, field secretary
Kenneth W. Bush, administrative assistant
James A. Waggener, executive secretary

Minutes of July 17, 1966, Council Meeting

On motion of Drs. Steen and Neumann, paragraph 1-b, under Matters from Committees and Commissions, was amended by striking the name "Kelly" and inserting the name "Kilborn" and also by striking the words "Welfare Department" and inserting the words "Blue Shield," making this paragraph read:

"b. Dr. Steen also discussed the problem of accepting assignments on over-65 welfare patients. He reported that Mr. Kilborn of Blue Shield said that Blue Shield is willing to break this contract if this is the wish of the Council. Mr. Kilborn asked for help of the state association in this matter."

On motion of Dr. Steen, seconded by several, the minutes of the July 17, 1966, Council meeting were approved as amended. These minutes were published in the October, 1966, *Journal.*

Minutes of June 12, 1966, Council Meeting

On motion of Dr. Taylor, seconded by several, minutes of the June 12, 1966, Council meeting were approved as corrected by the insertion of a paragraph concerning Dr. Francis Land's position with HEW, and an amendment to Dr. Corcoran's motion regarding reimbursement under PL 89-97. This motion now reads as follows:

"Dr. Corcoran moved that the AMA delegates be instructed to work for reimbursement under PL 89-97 under Part B on the basis that the requirement of a receipted bill be eliminated. The motion was lost for want of a second."

Reports of Councilors

DR. HILLIS, Eleventh District, reported that his district had met on September 21, 1966, at Kokomo. He introduced Dr. James Harshman, Kokomo, newly-elected alternate councilor of the district.

DR. BOWEN, Thirteenth District, reported that the annual meeting of the Thirteenth District on September 28, 1966, was one of the best attended meetings in many years and the afternoon program on auto accidents and injuries and the evening presentation of the ex-superintendent of Chicago schools were well received.

Reports of Guests

DR. GLENN W. IRWIN, Jr., dean, Indiana University School of Medicine:

Mr. Chairman, members and guests of the Council, I thought you might be interested in a report that we recently gave to the subcommittee of the Indiana General Assembly to study medical education. This report concerned primarily the budget which had been developed for the I.U. Statewide Plan for Medical Education. It is broken down into a capital and an operating budget for the next biennium. One of the major capital items is a first class communications network connecting at least 14 communities throughout the state. These communities include the four state universities and their regional campuses. The network also is near many of the private institutions of the state.

After considerable consultation, we have been advised to build a 10 megacycle network using microwave towers throughout the system. If the system is shared between medical and other higher educational programs, the estimated cost of such a system is about one million dollars for the Statewide Medical Education Plan.

This network will allow for several television, audio, computer lines to be in operation simultaneously. Recently private carriers such as Bell Telephone, Western Union, and others are becoming interested in building this kind of network, and it may be possible to reduce substantially this capital outlay. Communication equipment listed at a cost of $531,600 is for the television originating and receiving equipment projected for the 14 communities. This is based on the assumption that, on an average, two hospitals in each community would be included in the network. Our computer facility would enable us to program much of the medical library on tape and for quick availability of information throughout this communication network. This would include print-out machines in all of the areas so that the physician could have a typed copy of the information or the article requested.

The last capital item is an addition to Myers Hall at Bloomington, Indiana. This

was based on the predication that there could be some expansion in the number of entering students at our school of medicine if, for example, we do have more of our senior students in various programs throughout the state. This is a legislative decision, and involves the question of a second school of medicine in the state.

As far as the operating budget is concerned, there is a sizable item for salaries of interns and residents. As I have traveled over the state, I have been impressed by the frequency of the question of who will pay for the large program in internships and residencies? Is the patient in the hospital going to pay for this?

It is believed appropriate that the state consider payment of half of the salaries for interns and residents who are in approved non-university hospitals. Although community hospitals can obtain partial payment for these salaries from Medicare, it is a significant financial burden to cover all these costs. I would recommend the establishment of a council or board consisting of representatives of the school of medicine, the Indiana State Medical Association, the Hospital Association and others to administer this aspect of the I.U. statewide plan. A similar advisory group now exists for the Regional Medical Program submitted by Indiana.

There is provision in this budget for statewide faculty members. Those of you who are in private practice realize the tremendous pressure for your time, and therefore there is a budget provision for part-time and full-time faculty members over the state.

At this stage of development it is suggested that planning money be appropriated for the four state schools and potential other sites for the development of the preclinical aspects of this program (basic work for first year medical students in Indiana universities and colleges other than Indiana University.) The recommended budget for this project is $500,000.

You may be interested in the enrollment figures in September, 1966. There was a total of 816 medical students including those in the special Combined Degree Program at Bloomington. There were 262 interns, residents and fellows. There were 111 students in the graduate medical programs. The total student enrollment at the medical center, including dental and nursing students, was approximately 2,500. There were 23 separate educational programs being offered on the campus. The state of Indiana has a considerable investment in this large operation at the medical center. It is vital to our present commitments, as well as to the Indiana University Statewide Plan for Medical Education, that substantial strengthening of the faculty and increased facilities be provided during the next few years. The next budget request of the General Assembly will be large, but it will support not only the school of medicine but all of the many health professional programs being offered at the medical center campus. Thank you very much.

DR. A. C. OFFUTT, State Health Commissioner, discussed the following matters:

(1) *Family planning.* "We are continually getting pressures from many groups to develop a program in family planning. We would all be well advised to start thinking of what should be the content of such a program. Any Board of Health program will need very early involvement of organized medicine."

(2) *Use of 70 mm. film in chest x-rays of school employees.* "This matter was presented to the Council some eight or ten years ago and it was the decision of the Council at that time that the 70 mm. x-ray was not a diagnostic x-ray and that the intent of law was that a diagnostic x-ray should be provided. The situation has arisen again by reason of the improved methods in the use of 70 mm. x-ray and the taking of a 70 mm. x-ray, as to whether it would now be useful as a diagnostic film."

In answer to Dr. Corcoran's question, Dr. Offutt said that, in his opinion, it is the responsibility of the school administration to see that school employees are x-rayed.

Dr. Offutt stated that the State Board of Health would support Resolution No. 3 calling for legislation regarding tuberculin testing of pre-school children. (Discussed by Drs. Glock, Gosman and Hillis.)

(3) *The multiple handicapped.* "We have every reason to believe that there will be a tremendous amount of pressure in January on the General Assembly with regard to some kind of a law concerning the multiple handicapped. A committee, with no actual official status, has been working on the problem and if anything transpires, it will undoubtedly come from this committee."

(4) *Bill for state milk inspection.* "The legislative advisory commission produced this bill, I understand. In answer to their question, we estimated it would cost a half million dollars. In a few words, the bill provides for state milk inspection. Now this does not mean that there is no milk inspection today. It simply means that it is done by many people in lots of different ways, as some of you well know. This bill would provide for a better standard of operation and also that the state would do all of it. Now, obviously, we would propose in this program, as we have in many others, to subcontract this to local health departments who are competent to actually do the job. A word about the magnitude of this thing: there are about 5,100 Grade A producers who ship into Indiana; there are approximately 65 fluid milk pasteurization plants that operate in the state. Supervision would have to be provided for all of these people, which would be a tremendous amount of work over our present work schedule. Not very many local health departments presently operating in the state have a staff to go into this program."

(5) *Matter of dumps.* Dr. Offutt commented, "We are several years late in developing legislation to control the development and operation of open dumps. I predict that widespread support may not be easy when the proposal reaches the light of day."

(6) *State Board of Health subsidies to local health departments.* In answer to Dr. Neumann's query, Dr. Offutt confirmed the fact that there is a rumor that a bill might be introduced in the next legislature which would subsidize local health departments. If such a bill is introduced, Dr. Offutt said the State Board of Health would support it.

DR. GLEN V. RYAN, President, Blue Shield Board of Directors: Dr. Edwards, members of the Council and guests:

It would be needless to say that the past year has been a very trying year for not only Blue Shield but also for the medical profession. Blue Shield has found it necessary to make many adjustments to the changes, and we have been challenged with the changing of the practice of medicine, and have tried to adapt to it. I think that I can say that there have been more changes and more problems in the past year than there have been in the other 19 years in the history of Blue Shield. And in comparing the picture of September of '65 with what we saw in September of '66, I think we can elucidate on that a little bit.

Our regular claims volume has shown an increase of 15%. That's the regular business, since the inception of medicare the first of July. This has come about in the face of a predicted decline since our over-age 65 members are now a part of the Medicare program. We have also been faced with new demands for coverage in previously uncharted areas from our large buyers. For example, psychiatric benefits both on an out-patient and in-patient basis for General Motors, Ford, and Chrysler employees and also prenatal, delivery and postnatal care, the whole package for these same people was recently purchased. In September we received 20,000 claims from Medicare beneficiaries. Our administration of the Medicare program has made drastic changes in our total organization.

Our total number of employees has doubled since last year. As you know, this means growing pains and the training of young neophytes inexperienced in claim processing. Medicare administration also means dealing with government laws and regulations which sometimes just do not seem logical to a free, private enterprise operation.

But even amidst all these problems, including the attempt on the part of Blue Shield to adjust to the changing methods of billing from the radiologists and pathologists in addition to the problems I have just outlined, claim processing time is still approximately eight working days on our regular business and 15 working days for Medicare. Incidently, I am sure that you will be interested to know that 95% of those Medicare payments represent payment in full of the doctor's charge according to the latest survey.

This record has not been an easy accomplishment, believe me. It has been the result of a six-day work week for the last few months on the part of our loyal and conscientious employees. Probably not in the past 20 years has the need for a closer relationship and two-way communication between Blue Shield and the ISMA been so apparent.

As most of you know, this is the first time that the president of Blue Shield has officially been invited to the Council meeting. It seems to me that it is a move in the right direction. We talked about this, I've heard conversation about it for the past four years or so. But I would be glad to come to the Council meetings and I'm sure whoever might follow me as president would be glad to. Many of the little nagging, bickering problems that grow into big problems could be minimized by a little closer cooperation and a little closer communication between the Council of the state medical association and Blue Shield. The regular president's report is in printed form and will be in the brochure that will be given to all the delegates this afternoon which has to do with the finances and the test of performance. Thank you very much, gentlemen.

Unfinished Business

Amendment to Bylaws regarding conditions of membership. **On motion of Dr. Steen, seconded by several, the Council adopted the following amendment to Chapter XXVII, Section 4, of the Bylaws, as recommended by the Commission on Constitution and Bylaws in its 1966 annual report to the House of Delegates:**

"Provided, however, that each county society may deny membership in such society for infraction or violation of any law relating to the practice of medicine or of the Constitution and Bylaws of such society, the Constitution and Bylaws of the Indiana State Medical Association or for a violation of the Principles of Medical Ethics of the Indiana State Medical Association; and may, after due notice and hearing, censor, suspend or expel any member for any such infraction."

This sentence is to be inserted in this section after the first sentence and before the second and last sentence.

Reports of Officers

DR. KENNETH O. NEUMANN, President: Mr. Chairman, gentlemen. First of all, I would like to defer some of my remarks until later in the meeting. We do have coming in, later in this morning, an individual from HEW in Baltimore who will be here for a couple of hours to discuss the problem of certification, and I hope he will be here in time to meet with the Council. This is a man by the name of Whitcomb of the Bureau of Health Insurance, to whom I have talked a couple of times on the telephone. And he wants to come out and find out in the hinterlands what the problem is. I think I apprised him on most of it.

Regarding Blue Shield, I'm sure that all of you received the correspondence regarding the meeting with Blue Shield and the presentation that was made to the Blue Shield board, and I think this is pretty much self-explanatory as far as the welfare program is concerned. I have had subsequent correspondence on the matter of billing with Mr. Kilborn. I won't go into details on this except that some seven or eight weeks ago, those of us who do machine billing and those of us who do billing on Thermofax forms and this type of thing had attempted to secure a code so that we might use code billing and then this directive came out that we had to put all this information on the bill. This is a physical impossibility when you're doing machine billing. You cannot do it, other than hiring another girl and having her do it. Mr. Kilborn inquired of the Social Security office if some type of code billing was feasible and apparently they told him no. Now it's an amazing thing that HEW will permit coding for everything else but the physician's diagnosis. And I think this is tragic—and I think that the problem is going to be very complex if each one of these things has to be spelled out. Now he has written to the Department of HEW and asked them to reconsider this. When I was in Michigan a couple of weeks ago, I found that they are doing coding and I don't know why they can do it and we can't. There's something wrong. Could you answer that, Dr. Ryan?

DR. RYAN: Mr. Kilborn reported to the executive committee of Blue Shield yesterday noon and he feels that it can be done if we can just get the blessing of Social Security on it, and he did get the blessing of Social Security over the telephone, and he asked them for it in writing.

DR. NEUMANN: This is a big improvement, because it is an impossible situation for clinics and those of us who use machine billing to write this all out. I can see that if we had uniform coding and that if the doctors are willing to accept this method, it would be reasonable.

Now, I would like to defer my other remarks until later. I'm concerned considerably about the subsidization of local health departments by the State Board of Health. I think we all are; we know that when you subsidize something you control it, and I think that this is contrary to our idea.

DR. EUGENE S. RIFNER, President-elect: Your president-elect has attended since our last meeting, all of the executive committee meetings to date and on August 24th through the 26th attended the AMA public relations meeting in Chicago. It seemed to me while there that we found most of our public relations were a lack of ability to keep abreast of the times. Shopping centers were a new thing, but physicians hadn't found places to make medical facilities available and clung to large tall buildings within the city with little or no parking space. One gentlemen said that he would like for his wife to be able to get all her medical care in one small area. When questioned, he was not necessarily for clinics, but felt that men should ban together in doctors' buildings where laboratories, x-ray facilities and so forth were available. He did not advocate that these be at or near the hospital, necessarily.

At the president's meeting following this, we heard Dr. Philip Lee outline the programs of health legislation which would make your hair stand on end. It is quite obvious that the ISMA and the AMA must get abreast of the times and look for problems and solve them ahead of time. We certainly cannot continue in the same old manner as in the 30's and the 40's and perhaps the early 50's and find ourselves keeping up. We will be passed, and others will take us over.

I attended the I-HOPE meeting on September 7th and the I.U. advisory committee concerning regional development planning. This was held on September the 14th. I will await the House of Delegates' and the Council's policy concerning this organization. I am sure that I was put on this committee because of my position with ISMA but I do not feel I can take a stand for or against any part of these principles until such is aired in the coming House of Delegates.

I went to the 11th Medical District, which Dr. Hillis has reported.

On September 22nd, I went with Mr. Waggener to the meeting at the Social Security office in Indianapolis. The men from Chicago were present. It is my firm belief that in this meeting we accomplished one thing. We had the Social Security inform the carrier that it was no longer necessary to have a special form on the chart. This was followed by a public announcement by Blue Cross that this was not necessary. We were never able to get 1.) a definition of medical necessity, nor 2.) the exclusion of some form of actual certification. It is my

fear that the law asks for certification and that is going to be held to the letter of the law in some form or other. What we need at the present time is a compromise between the words "medical necessity" on a separate sheet of paper and the use of progress notes. Somewhere between these two lies a common goal that we might meet Social Security and continue to take care of the aged.

Concerning the Blue Shield matter that everybody is talking about, this is the Blue Shield and welfare matter. Our combined executive committees have met and formulated a contract which is now in the hands of the attorney general for approval or rewriting or what have you, and this is where the matter of the welfare stands at the moment.

I sometimes think as I begin this year that Perry Como's "We Get Letters" certainly fits Dr. Neumann and myself. And the song we are to sing is "To Make Everything As It Was." And the other stories we get are—What are you guys down at the state going to do about it? Now concerning where we go from here, with the contract with the welfare department and Blue Shield, we are going to do exactly what this Council and this House of Delegates tells us to do.

DR. OTTIS N. OLVEY, treasurer, reported that the association is in the black, with specific accounts as follows:

Cash Report

		Total
General Fund:		
Checking account	$22,312.32	
Savings	66,578.05	
Bills	62,000.00	
Securities	50,000.00	
		$200,890.37
Obligations:		
AMERF 1966 dues	19,320.00	
Reserves, 1st quarter, 1967 fiscal year	62,046.95	81,366.95
Cash and securities as of 9/30/66		$119,523.42
Summary of all Funds:		*Total*
General Fund:		
Cash	22,312.32	
Investments ...	178,578.05	$200,890.37
Journal Fund:		
Cash	1,257.21	1,257.21
Medical Defense Fund:		
Cash	1,727.59	
Investments ...	33,000.00	34,727.59
Building Fund:		
Cash	386.18	386.18
Building Fund:		
Auxiliary donation	3,777.71	3,777.71
Student Loan Fund:		
(old) Investments	9,000.00	9,000.00
Kitchen Fund:		
Investments ...	1,742.18	1,742.18
Total cash	$ 29,461.01	
Total investments	222,320.23	
TOTAL		$251,781.24

DR. FRANK B. RAMSEY, Editor of *The Journal*: Mr. Chairman, members of the Council, you will remember many times I have talked to you in the last few years when the financial report was in the form of a statement as to how many pages of paid advertising we had in each issue. That usually ran around 40 pages. October, this month, we have 60 pages. This is about twice what we had a year ago. Next month is even better, it runs to 80 pages for that issue. I think at least part of this improvement on our part is due to what we've been able to do in writing letters to the advertisers in expressing appreciation and interest in the advertisements which they place in our *Journal* and I want to urge the councilors to continue to do this and even expand the program a little bit. Each councilor should ask a few, two or three men who practice close to him, to join us in this project of writing the advertisers—at least one each month to say something about the advertising which they place in our *Journal*.

The second thing I want to tell you about has to do with the Internal Revenue Service plans, which have been spoken of before, to tax voluntary professional associations for that part of their income which is not directly related to their basic purpose. This was illustrated in 1963 by the Internal Revenue Service placing a claim against the *New England Journal of Medicine* and the Massachusetts State Medical Society for a tax bill of approximately a half a million dollars covering advertising revenue over a period of five years. The state medical society paid this under protest to avoid penalties and additions of interest to it, and after the check had been in for some two years, it was sent back to the state society and the case was cancelled.

The implications of this are very difficult to determine. It probably does not mean that the Internal Revenue Service has given up on this proposition. The idea of taxing revenue has come up in two forms recently. It originally came out, in fact, that all advertising revenue should be taxed, and then was modified to state that all revenue from advertising which was not used immediately for the cost of publication should be taxed. Now in our case and in the case of most state medical journals that would mean we wouldn't have any tax bill, because we could spend all our income. *The New England Journal* is different in the fact that they have had excess—what I. R. S. calls excess earnings—in the matter of almost a million dollars in five years. This case was started by the Boston district office without consultation with the Washington I. R. S., and it may have been started there without proper consideration. The district office may have embarrassed the Internal Revenue Service to the point that they find they were not able to prosecute the case in court and therefore have called it off. It may come up again later.

The third thing I should tell you about is in relation to our Editorial Board, and associate editors. Dr. Johnson from Richmond and from the Sixth District who has been on the Editorial Board for many years, has written me that he does not wish to be considered for re-election. Both he and Dr. Wilkens of Indianapolis have already been nominated for re-election to the Editorial Board, and Dr. Johnson, without knowing that fact, as far as I know, says now that he does not wish to be considered. Dr. Wilkens, of course, is an important part of our team. In relation to this, and in relation to what I spoke to you before about enlarging our editorial staff to take care of the type of medical literature which we hope to publish in the future, in relation to postgraduate and continuing medical education, and particularly in relation to what Dean Irwin has talked to us about this morning and statewide postgraduate education, I'd like to recommend that we enlarge the staff of associate editors by one, and for this purpose I'd like to recommend that Dr. Wilkens be elected as an associate editor and in his place on the Editorial Board as a doctor from Indianapolis, recommend Dr. Jack Hickman of Indianapolis who is the Director of Education at Marion County General Hospital and is very interested in *The Journal* and very willing to work on our staff.

Delegates to the AMA: Dr. Jones spoke of the many appointive positions that Indiana physicians hold at the present time in the AMA.

DR. LESTER D. BIBLER, AMA Board of Trustees member, commented on a number of matters:

1. *Dr. Frank Land's appointment as consultant for Dr. Winston in HEW.* "He is on the road practically half of the time, contacting various states and medical organizations relative to the administration of Title XIX. We hope, through this appointment, to have liaison with what is going on in Washington."

2. *Resolution 104*, passed by the AMA House of Delegates. "Due to a few letters from the Department of Justice, personal interviews, and legal consultation, the Board of Trustees determined that activation of this resolution should be deferred in order that the subject could be considered further." (Copies of a substitute resolution were distributed to the members of the Council).

3. *AMA Medicare Advisory Committee.* This committee has been disbanded and at the present time the president, president-elect, and chairman of the Board of Trustees are acting as a standby advisory group, awaiting further activity as to whether an advisory group should be re-affirmed or should be allowed to stand as at present until further changes are needed.

4. *The Viet Nam situation.* "Dr. Phelps is doing a fine job over there relative to doctors volunteering their services, and, as you know, this is operated under the U.S. Aid program."

5. *Committee on study, planning and developments.* This committee, activated by the Board of Trustees, is exploring the whole field of the American Medical Association and all its functions.

6. *Committee on Manpower,* which is studying the medical aspect as well as the ancillary groups of medicine. Dr. Dwight Wilbur, who is a member of this committee, is also a member of Johnson's Committee on Medical Manpower.

7. *Citation for distinguished service.* Alabama has suggested Senator Lister Hill for this citation, to be awarded by the AMA. Dr. Bibler asked for comments on this proposal.

8. *Subsidization of local health departments.* Dr. Bibler spoke of the experiences other states have had in this regard and suggested that Indiana should be careful in selecting its personnel.

9. *Millis committee.* John S. Millis, Ph.D., president of Western Reserve University, Cleveland, is chairman of this Citizens Commission on Graduate Medical Education, and retired Justice Charles E. Whittaker is a member. "I respect their judgment. The committee has made a very thorough coverage of this problem but there are several holes in this report and that's the reason we would like for all of you to study the booklet that has been published and particularly instruct your delegates or advise them of your reactions prior to the Las Vegas meeting."

Resolution on Statement of Policy Regarding Hospital-Physician Relations

A copy of the following resolution was handed to each member of the Council:

SUBJECT: STATEMENT OF POLICY REGARDING HOSPITAL-PHYSICIAN RELATIONS

WHEREAS, There is need for the American Medical Association to state its current policy position regarding hospital-physician relations; and

WHEREAS, Title XVIII of the Social Security Act recognizes the principle of the separation of professional and hospital costs for services rendered by hospital-based physicians; and

WHEREAS, This principle has been advocated by the American Medical Association, the American College of Radiology, the College of American Pathologists, and many regional organizations; and

WHEREAS, It is detrimental to the public interest and the medical profession when the services of hospital-based physicians are provided at a financial profit to the hospital; and

WHEREAS, It is necessary in the interest of the public and the medical profession that the services of all physicians, including hospital-based physicians, be clearly delineated, charged, and paid for as professional services; therefore be it

RESOLVED, That the American Medical Association hereby adopts the following statements of policy as its position with respect to hospital-physician relations:

1. Physicians and hospital authorities have the mutual responsibility to cooperate and work together effectively toward the constant goal of improving patient care and providing such care efficiently and at reasonable cost to the public.

2. Although final legal authority for granting, denying, terminating, or limiting hospital privileges may be vested in the governing board of the hospital, it is expected and necessary in the public interest that the governing board accept the determinations and judgment of the organized medical staff in the evaluation of professional competence, education, experience, ethical standards, and qualifications of all physicians, including hospital-based medical specialists.

3. In order to assure patients the services of professionally qualified ethical physicians, the contractual arrangements between hospital-based medical specialists should be subject to the condition that such physicians shall be admitted to the organized medical staff and retain membership in good standing in accordance with the same rules and procedures which apply to other members of the organized medical staff.

4. Hospital-based medical specialists are entitled to reasonable charges for their services. Hospitals are entitled to recover their costs, determined in accordance with recognized cost accounting principles, from the operation of departments in which hospital-based medical specialists perform their services. The addition of a profit to such costs by the hospital results directly or indirectly in increases in the cost of medical services and is opposed as detrimental to the public interest and the medical profession.

5. Constituent and component medical societies have a clear mandate to use every legally acceptable means to promote ethical contractual and separate billing arrangements between hospital-based physicians and hospitals in order that the services of these physicians may be provided to patients at reasonable charges and without inflation through the addition of hidden profits for the hospital, and in order that the independence and professional integrity of the medical profession may be preserved.

6. It is unethical for a physician to enter into any salaried or other contractual arrangement whereby a hospital engages in the illegal corporate practice of medicine.

Dr. Steen moved that the last sentence in paragraph 4, reading: "The addition of a profit to such costs by the hospital results directly or indirectly in increases in the cost of medical services and is opposed as detrimental to the public interest and the medical profession," be deleted and that the resolution be introduced to the House of Delegates in order that it might be referred to an appropriate reference committee for study to determine whether or not it should be introduced in the AMA House of Delegates at the interim session in November. Motion seconded by Dr. Corcoran. The motion was not put to vote.

Following discussion by Drs. Petrich, Rifner, Neumann, Bibler, Jones, Hoyt, Taylor, Montgomery and Wing, **on motion of Dr. Taylor, duly seconded, the Council voted that the proposed resolution be tabled indefinitely.**

Matters Referred to Council by Executive Committee

DR. RALPH V. EVERLY, chairman of the Executive Committee, presented the following matters:

1. *Better Business Bureau membership for 1967.* **On motion of Drs. Petrich and Reid, the Council authorized the payment of $175.00 for membership in the Better Business Bureau for 1967.**

2. *Resolution on Implementation of Title XIX.* Dr. Everly presented the following resolution for action of the Council:

WHEREAS, A proposed bill to implement Title XIX of Public Law 89-97 will be introduced in the 1967 session of the Indiana state legislature, and

WHEREAS, There is some confusion regarding the impact of this legislation in relation to the welfare of the citizens of this state and the duties and obligations of the medical and allied professions who must implement the law, and

WHEREAS, The Indiana State Medical Association is primarily concerned with the adequate provision of high quality medical care for the people of the state of Indiana, and

WHEREAS, As principal provider of medical care in this state, the physicians of

Indiana feel that they should be a principal participant in all planning or legislative action involved with the provision of medical care for our people, and

WHEREAS, The Indiana State Medical Association is concerned with the overall impact of the passage of laws to implement Title XIX, and

BE IT RESOLVED, That this House of Delegates of the Indiana State Medical Association adopt the following principles in regard to the implementation of Title XIX legislation in the state of Indiana:

1. The right of the patient to select his own physician and medical facility be guaranteed;
2. There be adequate representation of practicing physicians on the medical advisory committee to the state and local welfare departments and that the state or appropriate county medical society be consulted in regard to such appointments;
3. That there be a full-time medical director in the state welfare department with authority to enunciate medical policy;
4. The patient not be required to have prior authorization in order to obtain medical service;
5. The principle for reimbursement of physicians be on a usual and customary fee basis and that mechanics be included to permit direct billing of the patient by the physician;
6. A non-profit or other health insurance carriers be utilized in the implementation of these programs; and
7. Continued consideration be given to the feasibility of deductible and coinsurance features to promote more efficient implementation of the law.

Dr. Neumann moved that the words, "with the authority to enunciate medical policy" be deleted from paragraph 3. Motion seconded by Dr. Steen.

Dr. Hillis suggested that "medical director" be changed to "doctor of medicine as medical director," and this amendment to the amendment proposed by Dr. Steen was accepted by Dr. Steen. **On voting, these amendments were approved by the Council.** With these changes, paragraph 3 would read, "That there be a full-time doctor of medicine as medical director in the state welfare department."

Then **it was moved and seconded that the word "emergency" be inserted before the words, "medical service", in paragraph No. 4, making paragraph 4 read:**

"The patient not be required to have prior authorization in order to obtain emergency medical service."

The motion for this change in paragraph 4 was put to vote, and carried.

On motion duly made and seconded by several, the Council voted, 7 to 5, to strike out paragraph 7.

On motion of Drs. Petrich and Steen, the Council approved the resolution as a whole as amended. The resolution, as approved for presentation to the House of Delegates, reads as follows:

IMPLEMENTATION OF TITLE XIX

WHEREAS, A proposed bill to implement Title XIX of Public Law 89-97 will be introduced in the 1967 session of the Indiana state legislature, and,

WHEREAS, There is some confusion regarding the impact of this legislation in relation to the welfare of the citizens of this state and the duties and obligations of the medical and allied professions who must implement the law, and

WHEREAS, The Indiana State Medical Association is primarily concerned with the adequate provision of high quality medical care for the people of the state of Indiana, and

WHEREAS, As principal provider of medical care in this state, the physicians of Indiana feel that they should be a principal participant in all planning or legislative action involved with the provision of medical care for our people, and

WHEREAS, The Indiana State Medical Association is concerned with the overall impact of the passage of laws to implement Title XIX, and

BE IT RESOLVED, That this House of Delegates of the Indiana State Medical Association adopt the following principles in regard to the implementation of Title XIX legislation in the state of Indiana:

1. The right of the patient to select his own physician and medical facility be guaranteed;
2. There be adequate representation of practicing physicians on the medical advisory committee to the state and local welfare departments and that the state or appropriate county medical society be consulted in regard to such appointments;
3. That there be a full-time doctor of medicine as medical director in the state welfare department;
4. The patient not be required to have prior authorization in order to obtain emergency medical service;
5. The principle for reimbursement of physicians be on a usual and customary fee basis and that mechanics be included to permit direct billing of the patient by the physician;
6. A non-profit or other health insurance carriers be utilized in the implementation of these programs.

3. *Resolution No. 23.* This resolution, entitled, "Health Insurance," was recommended by the Executive Committee to the Council for acceptance and introduction to the House of Delegates. **Upon motion duly made and seconded, the Council accepted this resolution, which reads as follows:**

WHEREAS, several insurance companies require inpatient status in order to cover diagnosis and other services, and

WHEREAS, such requirement utilizes hospital beds unnecessarily since many such services can be done on an outpatient basis,

THEREFORE BE IT RESOLVED that the Indiana State Medical Association strongly recommends to the insurance carriers in the state that the inpatient status requirement be discontinued for these services in order to free as many hospital beds as possible so they may be utilized by patients with a definite medical need.

4. *Billing Blue Shield for drugs for welfare cases.* Mr. Waggener reported that this matter had been discussed with Mr. Kilborn of Blue Shield and Mr. Kelly of the Welfare Department and both Mr. Kilborn and Mr. Kelly had agreed that the charge for drugs dispensed to welfare patients could be included with the billing for other services and could be paid through Blue Shield, rather than requiring the physician to send these charges to two separate agencies, Blue Shield and the Welfare Department, as has been done in the past. **On motion of Drs. Rifner and Tindall, incorporating the charge for drugs in the billing for professional services to welfare patients, to be paid through Blue Shield, was approved by the Council.**

Economic and Organization Matters

1. Requests for remission of state dues of two members in the Tenth District, one because of retirement from practice, and the other because of a missionary assignment, were approved on motion of Dr. Steen, seconded by many.

2. *District nominations for Blue Shield Board of Directors for three-year terms ending March, 1970,* were confirmed as follows:

District

4 — Joe M. Black, Seymour, General Practice

7 — Glen V. Ryan, Indianapolis General Practice

10 — M. B. Gevirtz, Munster General Surgery

13 — Edward Dovey, Elkhart, Urology

Members at large, for three-year term ending March, 1970, are:

John W. Beeler, Indianapolis, Radiology
William E. Bayley, Lafayette, Pathology

3. *Election of two members to Editorial Board.* **On motion of Dr. Taylor, seconded by many, the Council approved the recommendations of Dr. Ramsey, editor of *The Journal*, for election of Dr. I. W. Wilkens, of Indianapolis, as an additional Associate Editor for 1967, and Dr. Jack Hickman, Indianapolis, as a member of the Editorial Board for the three-year term ending December 31, 1969.**

At a breakfast meeting of the Council on October 11, 1966, **on motion of Drs. Tindall and Green, Dr. Frank H. Coble, Richmond, was nominated and elected a member of the Editorial Board for the three-year term ending December 31, 1969.**

Matters from Committees and Commissions

1. *Contract between Welfare Department and Blue Shield.* The secretary reviewed the proposed revised contract between the Department of Public Welfare and Blue Shield, copies of which had been mailed to all officers and councilors in August, 1966.

2. *Council Committee on Emergency Room Problems in Hospitals.* Dr. Hillis, chairman of the committee, read the following rough draft of a resolution which had been tentatively approved by Judge Hamill and with which the members of the Council Committee on Emergency Room Problems had agreed in principle, **and on the basis of these facts Dr. Hillis moved that the intent of this rough draft be approved by the Council with the understanding that it be re-written in more legal terms, for presentation to the House of Delegates. Motion seconded by Dr. Steen.**

RESOLUTION ON HOSPITAL EMERGENCY DEPARTMENT OPERATION

WHEREAS, All general hospitals in the state of Indiana are required by law to provide emergency care facilities, and since these are no longer used only to treat acute accident victims, the concept of an emergency *room* is giving way to the concept of an emergency *department*: and

WHEREAS, hospital emergency department visits have increased more than 170% in the past 10 years, and

1. The dramatic increase in emergency cases has not been matched with dynamic efforts for an upgrading of services.
2. There is no uniformity among communities for emergency medical care.
3. There is a lack of staff and facilities in many small hospitals.
4. The use of emergency facilities as an after-hours physician's office finds people with non-emergencies in almost every emergency department.
5. Many specialists do not wish to accept the responsibility for patient care outside of his own field of interest.
6. Many insurance plans cover emergency department visits but do not cover office visits and house calls.
7. Many physicians arrange hours by appointments only, leaving no room for the patient with unexpected problems to be seen in the office.
8. Many physicians refer patients to the emergency department of the hospital where multiple diagnostic facilities are available.

NOW, THEREFORE, BE IT RESOLVED, that this House of Delegates of the ISMA adopt the following statements of principle:

1. Physician staffing of an emergency department must be a joint responsibility of the hospital administrator and the medical staff.
2. The emergency department physician staff must be under control of a committee of one or more members of the medical staff.
3. Physicians must not be compelled to serve on the emergency department staff under threat of loss of any staff privilege.
4. Specialist members of a hospital staff must be available for consultation with emergency department physicians.
5. Any hospital-based physician, or group of physicians, covering an emergency department must be ethical. They should bill their patients rather than accept a salary from the hospital.
6. If any subsidy is necessary to get emergency department coverage it should come from the medical staff or possibly from the county medical society and not from the hospital.

Following discussion by Drs. Steen, Hoyt, Gosman and Kerr, **Dr. Taylor's motion that this resolution be tabled until it was printed was seconded by Dr. Petrich, put to vote, and carried.**

Later in the meeting printed copies were distributed to the Council and **Dr. Steen's motion that the resolution be taken off the table was duly seconded, put to vote, and carried.**

The resolution was discussed further by Drs. Steen and Hillis. Dr. Hillis commented, "My position is that the contents of this resolution in most cases are direct quotations from various sources of material which have been selected in the preparation of this report, and that the resolution fills a need for the practice of medicine in the smaller hospitals of this state."

Drs. Petrich and Reid also discussed the resolution.

On motion of Drs. Steen and Kerr, the Council approved the following amendments to the resolution:

1. Under the WHEREAS, deletion of paragraph 5, and paragraph 6 to be numbered paragraph 5.
2. Deletion of paragraphs 7 and 8 under the WHEREASES.
3. Under NOW, THEREFORE BE IT RESOLVED, deletion of paragraphs 3 and 4. Paragraph 5 to be numbered paragraph 3, and paragraph 6 to be numbered paragraph 4.
4. Add a paragraph numbered 5 which states:
   "Specialists who do not care to accept the responsibility for patient care outside his own field of interest shall obtain the appropriate coverage for that patient."
5. Add a paragraph 6, reading:
   "Physicians who arrange hours by appointment only should make appropriate arrangements to be able to see emergency illness in his office."
6. Deletion of the words, "hospital-based" in former paragraph 5, now numbered paragraph 3.

The resolution, as amended and approved by the Council for presentation to the House of Delegates, follows:

WHEREAS, All general hospitals in the state of Indiana are required by law to provide emergency care facilities, and since these are no longer used only to treat acute accident victims, the concept of an emergency *room* is giving way to the concept of an emergency *department*, and

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3. Any physician, or group of physicians, covering an emergency department should be ethical. They should bill their patients rather than accept a salary from the hospital.

4. If any subsidy is necessary to get emergency department coverage it should come from the hospital administration medical staff or possibly from the county medical society.

5. Specialists who do not care to accept the responsibility for patient care outside his own field of interest, shall obtain appropriate coverage.

6. Physicians who arrange hours by appointment only, should make appropriate arrangements to be able to see emergency illness in his office.

3. *Recommendations of Commission on Constitution and Bylaws*:

a. The matter of the voting privilege of the alternate councilor to the councilor who serves as chairman of the Council was referred by the Council to the Commission on Constitution and Bylaws. The Commission on Constitution and Bylaws recommended that this suggested change should not be made, for the following reasons:

(1) The chairman of the Council may step out of the room and allow his alternate to vote.

(2) If the chairman was from a relatively small district, giving his alternate the right to vote would be unfair to the other districts, inasmuch as the chair does have the right to vote.

(3) The chairman of the Council can and does represent his district.

On motion of Dr. Steen, seconded by many, the Council accepted the recommendation of the Commission on Constitution and Bylaws.

b. The subject of re-apportionment of delegates was referred by the Council to the Commission on Constitution and Bylaws in January, 1966. **By consent, the Council accepted the recommendation of the Commission on Constitution and Bylaws that no change should be made in the present method of selection of delegates, and in the present apportionment of delegates.** It is the opinion of the commission that the present method of selecting delegates is fair and equitable.

New Business

1. **On motion of Drs. Corcoran and Kerr, the Council approved the following resolution and referred it to the Commission on Constitution and Bylaws:**

"That Chapter IV, Section 8, of the Bylaws be amended that roll call votes as stipulated herein may be defined to include written or printed ballots with the name and office of the member voting and in whatever form and manner as may be determined by the presiding officer."

2. *Resolutions to be introduced in the House of Delegates.* Each councilor was supplied with copies of all resolutions to be introduced in the House of Delegates, several of which were discussed briefly.

Date for January Meeting

By consent, January 22, 1967, was selected for the next meeting of the Council.

There being no further business the Council adjourned, to meet again on Thursday, October 13, 1966, in the Mural Room, French Lick-Sheraton Hotel, French Lick, immediately following adjournment of the House of Delegates.

THE COUNCIL

French Lick, Indiana
October 13, 1966

The Council met in the Mural Room of the French Lick-Sheraton Hotel, French Lick, Indiana, at the conclusion of the final session of the House of Delegates on Thursday, October 13, 1966, with a quorum present.

The meeting was called to order by the president, Dr. Eugene S. Rifner, in the absence of the chairman, Dr. E. T. Edwards.

Dr. Wilbert McIntosh and Dr. James A. Harshman were welcomed as new members of the Council.

Chairman of Council. By secret ballot, Dr. Lowell H. Steen, Whiting, was elected chairman of the Council for 1966-67.

Executive Committee. Upon motion duly made, seconded, and carried, Dr. Ralph V. Everly was re-elected to the Executive Committee, and Dr. Burton E. Kintner was elected to the Executive Committee to fill the vacancy left by Dr. Larson, president-elect.

There being no further business the Council adjourned to meet again with the AMA delegates at 10:00 a.m. on Sunday, November 20, 1966. ◄

COMMERCIAL ANNOUNCEMENTS

FOR SALE: ABERDEEN-ANGUS BULLS, P.R.I. production qualified for advanced register, predominantly Scotch breeding. Also, frozen semen, from P.R.I. and C.M.S. double registered and progeny proven sires. Write for information. Address: WYE PLANTATION, Queenstown, Maryland 21658. Telephones: Office, 301-827-2041; Residence, 301-827-8143. VISITORS WELCOME.

PHARMACIST desires to start professional pharmacy in new or established medical building. Interested physicians please write Box 332, The Journal, ISMA, 3935 N. Meridian St., Indianapolis, Indiana 46208.

OPHTHALMOLOGIST: Vigo County, Terre Haute. Population 72,000. Opening at A.P. and S. Clinic. Three colleges, two accredited hospitals. Contact Robert R. Brown, M.D., 221 S. Sixth St., Terre Haute, Ind., or phone collect Lincoln 8071.

SURGEON: Associate needed in proctology, board certified or eligible, American Board of Surgery, who will limit his field to colo-rectal surgery; or American Board of Colon and Rectal Surgery. Write Box 327, The Journal, ISMA, 3935 N. Meridian St., Indianapolis, Ind.

ORTHOPEDICS: Vigo County, Terre Haute. Population 72,000. Opening at A. P. and S. Clinic. Three colleges, two accredited hospitals. Contact Robert R. Brown, M.D., 221 S. Sixth St., Terre Haute, Ind., or phone collect Lincoln 8071.

PHYSICIANS WANTED: General surgeon, internist, family physician (generalist) interested in satisfying practice with time for home life. Long established mixed generalist and specialist group in Greater Kansas City area. Rapidly growing community; excellent hospital facilities. Salary one year, then partnership. Write Box 333, The Journal, ISMA, 3935 N. Meridian St., Indianapolis, Indiana 46208.

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OTOLARYNGOLOGIST: Vigo County, Terre Haute, Population 72,000. Opening at A. P. and S. Clinic. Three colleges, two accredited hospitals. Contact Robert R. Brown, M.D., 221 S. Sixth St., Terre Haute, Ind., or phone collect Lincoln 8071.

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AVAILABLE: Equipped physician's office available immediately due to death. Community of 2,600; drawing area of 8,000. Practice active 20 years. New location two years ago. Contact Robert A. Cox, D.D.S., 3 Parkview Court, Cambridge City, Ind. Phone 35191 for details.

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GENERAL PRACTICE AVAILABLE NOW due to death. Fully-equipped and furnished 5-room suite at no cost in professional building. All services furnished. Doctor urgently needed. Inquire R. C. Carson, 555 W. 92nd St., Indianapolis. Phone 846-8524.

HEALTH COMMISSIONER: Gary, Indiana. Salary $18,500. Full-time. Experience in public health preferred. Contact Samuel J. Brady, M.D., 504 Broadway, Gary, Indiana or phone collect 219-883-5166.

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The JOURNAL

of the

INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

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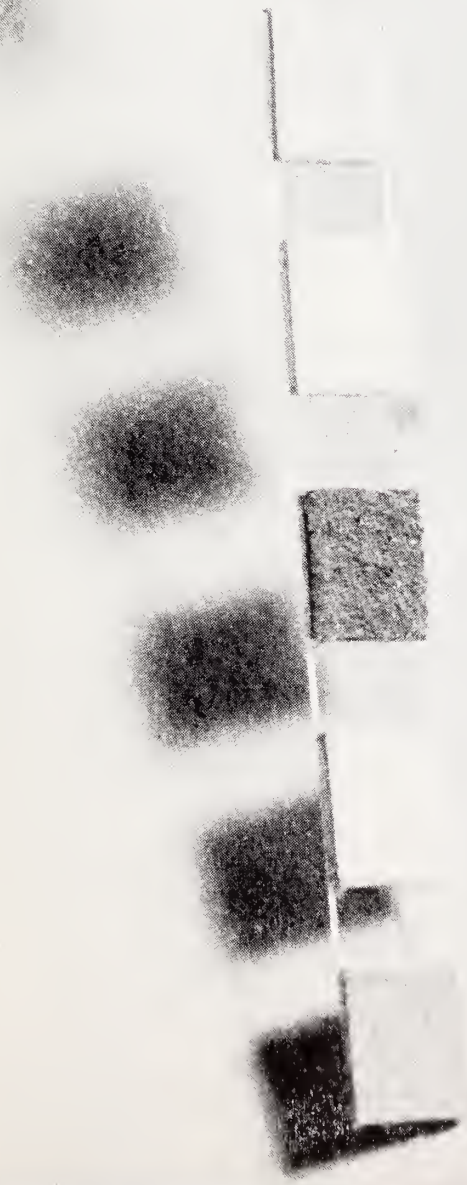

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Side Effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances and hallucinations) and changes in EEG patterns. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

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